21 1

17318

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17317

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C. MARYLAND
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47.3
d. STREET ADDRESS: 4217 Van Ness
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Ross Last: Neal
4. DATE OF DEATH: Month: Dec. Day: 8 Year: 1967
5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 9 - 1910
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY: GM. HIAA
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Ross Neal
14. MOTHER'S MAIDEN NAME: Flora Dempsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): W W I Navy
16. SOCIAL SECURITY NO.: 351-03-3121
17. INFORMANT: Marvin Neal Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO
(b) Advanced severe coronary arteriosclerosis — years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 19 Apr. 1959, to Dec, 1967, that (I) (we) last saw the deceased alive on 1 Dec 1967, and that death occurred at 4:40 p M, from causes and on the date stated above.

22a. SIGNATURE: Herbert Martyn Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9 Dec 67
22c. PHYSICIAN'S NAME (Type): HERBERT MARTYN JR
22d. ADDRESS: 4740 Chevy Chase Dr Ch. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12/12/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: Joseph Gawler's Sons Inc. ADDRESS: 5130 Wisconsin Ave. N.W. Wash, D.C.
25a. REC'D BY REGISTRAR DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

17318

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17318

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 45days

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4216 Anthony Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

3. NAME OF DECEASED (Type or print): First George Middle Y. Last NEWHOUSE

4. DATE OF DEATH: Month December Day 21 Year 19 67

5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 30, 1921
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Romney, West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Newhouse
14. MOTHER'S MAIDEN NAME: Zona Shank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 1942-1962
16. SOCIAL SECURITY NO. 232 26 0598
17. INFORMANT Mrs. Margaret B. Newhouse, 4216 Anthony Street Address Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the urinary bladder
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Nov. 7, 19 67, to Dec. 21, 19 67 that I (we) last saw the deceased alive on Dec. 21 19 67, and that death occurred at 0655 M, from causes and on the date stated above.

22a. SIGNATURE: Lawrence A. Jones M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: Dec. 21, 1967
22c. PHYSICIAN'S NAME (Type): Lawrence A. Jones, M. D.
22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/24/67
23c. NAME OF CEMETERY OR CREMATORY: Indian Mound Cemetery
23d. LOCATION (City or Town) (County) (State): Romney, West Virginia

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home ADDRESS: 1331 Rockville Pike, Rockville, Maryland
25a. REC'D BY REGISTRAR DATE DEC 28 1967
25b. REGISTRAR'S SIGNATURE: Richard Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

17320

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17319

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
d. STREET ADDRESS: Rt # 2 Box 49
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILFRED Middle Donald Last NICHOLSON
4. DATE OF DEATH: Month Dec Day 26 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/15/18
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Animal Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: N/H
11. BIRTHPLACE (County & State, or foreign country): Comus Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George E Nicholson
14. MOTHER'S MAIDEN NAME: Mary C. Whipp
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-30-8285
17. INFORMANT: Donald Nicholson Son Address: 10413 Montrose Place Beth. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis of the liver — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5810
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypokalemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec, 1952 to Dec 26, 1967, that (I) (we) last saw the deceased alive on Dec 26 1967, and that death occurred at 8:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: John G Fawcett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 27, 1967
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/29/67
23c. NAME OF CEMETERY OR CREMATORY: Monocacy
23d. LOCATION (City or Town) (County) (State): Dickersville Monty. Md
24. FUNERAL DIRECTOR: William B. Hillen
ADDRESS: Barnesville Md
25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17321 17320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POOLESVILLE
d. STREET ADDRESS: 15-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle W. Last NORRIS
4. DATE OF DEATH: Month DEC Day 20 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/15/08
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWNER
10b. KIND OF BUSINESS OR INDUSTRY: NORRIS LUMBER & FUEL
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CHARLES NORRIS
14. MOTHER'S MAIDEN NAME: CORA BOWMAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-09-1672
17. INFORMANT: VERA — Address: WIFE — SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction
4201
DUE TO (b): coronary arteriosclerosis with thrombosis
DUE TO (c):
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 1965 to 12/20, 1967, that (I) (we) last saw the deceased alive on 12/20, 1967, and that death occurred at 9:00 AM, from causes and on the date stated above.

22a. SIGNATURE: Robert Macon M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/20/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 809 Viers Mill Rd, Rockville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/22/67
23c. NAME OF CEMETERY OR CREMATORY: Monocacy
23d. LOCATION (City or Town) (County) (State): Beallsville Montg. Md.
24. FUNERAL DIRECTOR: William C. Hilton — ADDRESS: Barnesville, Md.
25a. REC'D BY REGISTRAR — DATE DEC 27 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17322

CERTIFICATE OF DEATH

17321

1. PLACE OF DEATH
a. COUNTY: Montgomery County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton, Md
c. LENGTH OF STAY IN 1b: Admitted 3-1-67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Randolph Hills Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 121 Bradford Rd. ~~Rex Crest Home~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15.1

90

3. NAME OF DECEASED (Type or print): First: Anna Middle: Last: Nwell

4. DATE OF DEATH: Month: December Day: 12/13 Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: Aug. 10 1870
9. AGE (In years last birthday): 97 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Isaac A. Beckett
14. MOTHER'S MAIDEN NAME: Susan Milan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 219-54-7772
17. INFORMANT: Brooks E. Soderstrum Address: 9039 Sligo Creek Pkwy Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peripheral vascular collaps — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b) Myocardial infarct — minutes
DUE TO (c) Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old age (97)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. I certify that (I) (this hospital) attended the deceased from March, 1967, to 12/13, 1967, that (I) (we) last saw the deceased alive on 12/15 1967, and that death occurred at 9:40 A.M., from causes and on the date stated above.

22a. SIGNATURE: Richard Delaney M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/14/1967
22c. PHYSICIAN'S NAME (Type): Richard Delandy
22d. ADDRESS: 4323 HAWARD ST. SILVERSPRING, MD.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mount Moriah Cemetery
23d. LOCATION (City or Town) (County) (State): Kansas City, Missouri

24. FUNERAL DIRECTOR: C. Glen Carter ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17323

CERTIFICATE OF DEATH

17322

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 7401 New Hampshire Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George; Middle: Edward; Last: Noyes

4. DATE OF DEATH: Month: 12; Day: 16; Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-7-93
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Std. Oil Corp.
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clarence Noyes
14. MOTHER'S MAIDEN NAME: Isabel Duguid

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-05-9877
17. INFORMANT: Chart — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adams Stokes Attacks — Minutes
DUE TO (b): Myocardial infarction — hours
DUE TO (c): Arteriosclerosis obliterans — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/13, 1967, to 12/16, 1967 that (I) (we) last saw the deceased alive on 12/16 1967, and that death occurred at 11:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: Kenneth Cruze
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/16/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-20-67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince George, Md.

24. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: Washington, D.C.
25a. REC'D BY REGISTRAR DATE: DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

17324

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17323

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING 151
d. STREET ADDRESS: 1602 CAREY LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Martin AGNES Middle (NMN) Last O'CONNOR
4. DATE OF DEATH: Month 12 Day 25 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1-6-02
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): WASH. D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: FRANK B MARTIN
14. MOTHER'S MAIDEN NAME: GRACE McCHESNEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-54-7655
17. INFORMANT: Pt's. CHART Martin O'Connor Address: 461 H St. NW, Wash., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest during Surgery
4200
DUE TO (b) associated with Arteriosclerotic
DUE TO (c) Heart Disease + Arrhythmias
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BELDEN R. REAP M.D.
Address (Street, city, town, or county): Bethesda
22. DATE SIGNED: DEC. 26, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek
23d. LOCATION (City or Town) (County) (State): Washington, D.C.

24. FUNERAL DIRECTOR: John B. Thomas
ADDRESS: Warner E. Humphrey, Inc., 8434 Ga. Ave., S.S., Md.
25a. REC'D BY REGISTRAR DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

17325

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17324

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda.
c. LENGTH OF STAY IN 1b: DOA.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen-Echo Hights. 15,1
d. STREET ADDRESS: 5424 Mohican Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William. Middle: Nelson Last: Oliver
4. DATE OF DEATH: Month: Dec. Day: 9 Year: 1967
5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 13, 1900
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Agent
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Joseph A. Oliver
14. MOTHER'S MAIDEN NAME: Anna Kinsinger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-44-5350
17. INFORMANT: Wife Linda P. Oliver — Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Smoke inhalation & Carbon Monoxide Poisoning
DUE TO (c): Conflagration (Fire in home)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
900.0
INTERVAL BETWEEN ONSET AND DEATH: minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House caught fire while asleep.
20c. TIME OF INJURY Month, Day, Year: Hour a.m. 12:45 p.m. Dec. 9 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home.
20f. (City or town) Glen Echo Hgts. (County) Montgomery (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bethesda, Md.
22. DATE SIGNED: 12/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-13-67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City or Town) Suitland (County) Pr, Geo (State) Md

24. FUNERAL DIRECTOR: Robert A Pumphrey ADDRESS: 7557 Wisconsin Ave Bethesda, Md
25a. REC'D BY REGISTRAR DATE: DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

17326

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17325

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 33 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 306 Reading Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

151

3. NAME OF DECEASED (Type or print): First: Herbert C. Middle: Last: ORAM
4. DATE OF DEATH: Month: 12 Day: 14 Year: 1967
5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4 SEPT 1895
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy
10b. KIND OF BUSINESS OR INDUSTRY: Military
11. BIRTHPLACE (County & State, or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Information not available
14. MOTHER'S MAIDEN NAME: Information not available
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): Not known
16. SOCIAL SECURITY NO.: Not known
17. INFORMANT: Leona Oram Address: 306 Reading Ave Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) BILATERAL CONFLUENT LOBULAR PNEUMONITIS
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

490X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 13 NOV, 1967 to 14 DEC, 1967, that (I) (we) last saw the deceased ~~alive on~~ 14 DEC 1967, and that death occurred at 7:00 P.M. from causes and on the date stated above.

22a. SIGNATURE: E. Perlin — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 16 DECEMBER 67
22c. PHYSICIAN'S NAME (Type): E. PERLIN, LCDR, MC, USN
22d. ADDRESS: NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/19/67
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville, Maryland
24. FUNERAL DIRECTOR: Tyson & Wheeler, Rockville, Maryland ADDRESS: 1331 Montgomery Ave.
25a. REC'D BY REGISTRAR DATE DEC 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

1

17327

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17326

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN. & HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8105 EASTERN AVE #314
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARLEY; Middle; Last OSWALT

4. DATE OF DEATH: Month 12 - Day 26 - Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 7-1-86
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): MISSISSIPPI
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: George Goff ~~OSWALT~~
14. MOTHER'S MAIDEN NAME: SYBIL WHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 213-54-6661
17. INFORMANT: GRACE OSWALT - SAME
Address: 8105 Easter Ave., S.S. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — Interval between onset and death: Sudden
DUE TO (b) Generalized Coronary Sclerosis — 17 yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year / Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/6/ 1950, to 12/26/ 1967, that (I) (we) last saw the deceased alive on 12/17/ 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: H. J. Morse
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/26/67
22c. PHYSICIAN'S NAME (Type): H. J. Morse
22d. ADDRESS: 7030 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-Burial
23b. DATE THEREOF: Dec. 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Lakewood Memorial Park
23d. LOCATION (City or Town) (County) (State): Jackson, Mississippi

24. FUNERAL DIRECTOR: C. Glen Carter
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
Warner E. Pumphrey, Inc.

25a. REC'D BY REGISTRAR
DATE JAN 4 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

CLEARED WITH DR. REAP, B.B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

12 1

FOR STATE HEALTH DEPT.

17328

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17327

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 26 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12800 Seaberry Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-1

3. NAME OF DECEASED (Type or print): First MORRIS Middle — Last PARELMAN

4. DATE OF DEATH: Month DEC. Day 24 Year 1967

5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/20/1882
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Businessness
10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Parelman
14. MOTHER'S MAIDEN NAME: CECILE (UNK) ~~HALPREN~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: SAMUEL T. PARELMAN Address: 1060 Y BUCKNELL DR SSA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Failure
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BELDEN R. REAP, M.D. Address (Town, City or Town, County): Wheaton
22. DATE SIGNED: DEC. 24 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/26/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Sharon Cem
23d. LOCATION (City or Town) (County) (State): Rock. Cou., Md.

24. FUNERAL DIRECTOR: Sadaley Funeral Home
ADDRESS: 4217-9th Ave
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

17329

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CHEVY CHASE NURS. & CONV. CENTER

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C. — b. COUNTY: --------
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: Washington, D. C. 4000 Mass. Ave., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth (BETTY) Middle: Bobman Last: PARIS
4. DATE OF DEATH: Month: Dec. Day: 12 Year: 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/11/02
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Julius Bobman
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 579-58-8043
17. INFORMANT: Robert Paris — Address: 900 Clintwood Dr. Sil. Spr. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular accident — IMMEDIATE
DUE TO (b): Cerebral Arteri-sclerosis — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1950, 19__, to Dec. 12, 1967, that (I) (we) last saw the deceased alive on Dec 11 1967, and that death occurred at 2.2 M, from causes and on the date stated above.

22a. SIGNATURE: LeRoy Robins — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-12-67
22c. PHYSICIAN'S NAME (Type): Le ROY ROBINS
22d. ADDRESS: 2480 16th St., N. W., Wash., D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/14/67
23c. NAME OF CEMETERY OR CREMATORY: Roosevelt Cemetery
23d. LOCATION (City or Town) (County) (State): Philadelphia, Pa.
24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th St., N.W.
25a. REC'D BY REGISTRAR DATE DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Jessye

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17330

CERTIFICATE OF DEATH

17329

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: U.D.H.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 4411 - Chase Avenue
d. STREET ADDRESS: Bethesda
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harry; Middle: ; Last: Patten
4. DATE OF DEATH: Month: Dec.; Day: 31; Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ WIDOWED ☐ NEVER MARRIED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB. 18, 1919
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter Contractor
10b. KIND OF BUSINESS OR INDUSTRY: private
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Sidney Patten
14. MOTHER'S MAIDEN NAME: Bertha ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 191-18-0846
17. INFORMANT: Wife - Elizabeth Patten. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 6 wks
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1950 to Dec 31, 1967, that (I) (we) last saw the deceased alive on Dec 25 1967, and that death occurred at 5:30 p.m. from causes and on the date stated above.

22a. SIGNATURE: Leo L Donovan M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/31/67
22c. PHYSICIAN'S NAME (Type): DR. LEO DONOVAN
22d. ADDRESS: 8218 WISCONSIN AVE BETHESDA

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-5-68
23c. NAME OF CEMETERY OR CREMATORY: Baltimore Natl Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland
24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: JAN 5 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Jordan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

17331

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17330

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Dist. of Col. — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington — 47.3
d. STREET ADDRESS: 115 Wayne Pl. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Demetria — Middle: Lynn — Last: Perminter
4. DATE OF DEATH: Month: Dec. — Day: 22 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 15 1967
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months 11, Days 7 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Perminter
14. MOTHER'S MAIDEN NAME: Dorothy Browder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dorothy Perminter — Address: Mother same.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 h.
491X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Bell M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 12/23/67.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/26/67
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): BEAVER FALLS, PA.

24. FUNERAL DIRECTOR: W. W. CHAMBERS CO. — ADDRESS: 5112 Ct. S.E. WASH. D.C.
25a. REC'D BY REGISTRAR DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

7-75

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17332

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Maryland
d. STREET ADDRESS: 8811 Colesville Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ruth Middle: Z Last: Philpott
4. DATE OF DEATH: Month: Dec. Day: 18 Year: 1967
5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/8/04
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: — —
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: H.E. ZERNER
14. MOTHER'S MAIDEN NAME: MAY RISTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): — — —
16. SOCIAL SECURITY NO.: — — —
17. INFORMANT: HAROLD M. PHILPOTT - SEE ITEM #2. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute lymphatic leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO
(b) Lymphosarcoma — 15 mos.
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2001
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from August, 1966, to 12/18, 1967, that (I) (~~we~~) last saw the deceased alive on 12/18 1967, and that death accurred at 9:30 P M, from causes and on the date stated above.

22a. SIGNATURE: G. Lennard Gold M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/19/67
22c. PHYSICIAN'S NAME (Type): G. Lennard Gold, M.D.
22d. ADDRESS: 8641 Colesville Rd., Sil. Spr., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 12-19-1967
23c. NAME OF CEMETERY OR CREMATORY: Oak Park Cemetery
23d. LOCATION (City or Town) (County) (State): New Castle, Pa.
24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
25M 1/67

17333

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 17332

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beth esda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3732 Manor Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-1

70

3. NAME OF DECEASED (Type or print): First: Jean — Middle: R. — Last: Pitzer

4. DATE OF DEATH: Month: 12 — Day: 5 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-3-78
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Rixey
14. MOTHER'S MAIDEN NAME: Mary F. Wise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: - - -
INFORMANT: Miss Frankie R. Keyser-Niece-
Address: 8320 26th Ave. Adelphi, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: ½ hour
DUE TO
(b) Arteriosclerotic heart disease — 20 yrs.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/12, 1965, to 12/5, 1967, that I last saw the deceased alive on 12/3, 1967, and that death occurred at 9:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John D. Griswold M.D.
ADDRESS (Street, city or town, state): 4830 V Street, N. W. Washington, D. C. 20007
DATE SIGNED: 12-5-67
PHYSICIAN'S NAME (Type): John D. Griswold, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 12-7-1967
22c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
22d. LOCATION (City, town, or county) (State): Culpepper, Va.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC
24a. REC'D BY REGISTRAR DATE: DEC 11 1967
24b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

17334

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6017 Neilwood Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6017 Neilwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: — Last: PLATT
4. DATE OF DEATH: Month: December — Day: 8 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 30, 1890
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Zalman Landow
14. MOTHER'S MAIDEN NAME: Mollie ? ? ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 169-16-8259 D
17. INFORMANT: Nathan Platt — Address: 9332 Harvey Road, Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — Acute
DUE TO (b): Art. Hypertensive Heart Dis.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: yrs
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-24, 1967, to 12-5, 1967, that (I) (we) last saw the deceased alive on 12-5 1967, and that death occurred at 6 PM, from causes and on the date stated above.

22a. SIGNATURE: Isidore Shulman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-9-1967
22c. PHYSICIAN'S NAME (Type): Isidore Shulman, M. D.
22d. ADDRESS: 915 19th Street N. W. Washington, D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-10-1967
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City or Town) (County) (State): Falls Church Va.
24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th St., N.W.
25a. REC'D BY REGISTRAR DATE DEC 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

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17335

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17334

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAYTONSVILLE
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-1

3. NAME OF DECEASED (Type or print): First ROBERT Middle LAMAR Last PLUMMER
4. DATE OF DEATH: Month 12 Day 6 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-13-92
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: CARPENTER
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: HOWARD A. PLUMMER
14. MOTHER'S MAIDEN NAME: R. IDA CRAWFORD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 218-10-8492
17. INFORMANT: MEDICAL RECORD DEPT. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident - basilar artery — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
331X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia, Diabetes mellitus, chronic lymphatic leukemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 1965, to Dec. 6, 1967, that (I) (we) last saw the deceased alive on Dec 6 1967, and that death occurred at 3:03 P.M., from causes and on the date stated above.

22a. SIGNATURE: Frederick Moomau M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-6-67
22c. PHYSICIAN'S NAME (Type): FREDERICK MOOMAU, M. D.
22d. ADDRESS: MEDICAL CENTER, SANDY SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-9-67
23c. NAME OF CEMETERY OR CREMATORY: Laytonsville
23d. LOCATION (City or Town) (County) (State): Laytonsville Mont Md.
24. FUNERAL DIRECTOR: Francis H. Barber ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE: DEC 8 1967
25b. REGISTRAR'S SIGNATURE: Melvin L. Judge

VR A15 (4)
25M 1/67

Items 18-21 Film 396
1-15-68 ams

17336

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17335

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form ... Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN Hospital: 23 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
d. STREET ADDRESS: Box 101, Sandy Spring Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First George, Middle Alexander, Last Powell
4. DATE OF DEATH: Month 12, Day 9, Year 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 6/11/08
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dishwasher
10b. KIND OF BUSINESS OR INDUSTRY: Hospital 7
11. BIRTHPLACE (State or foreign country): Sandy Spring Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: A.Chase
14. MOTHER'S MAIDEN NAME: Imma Powell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Brother/Milton Powell/Sandy Spring Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock and acute diffuse purulent
DUE TO
(b) peritonitis due to traumatic rupture
DUE TO
(c) of ileum

816.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased, driver, collided head-on with another auto.
20c. TIME OF INJURY Month, Day, Year: hour a.m. p.m. 4:48 12-8 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) Rockville (County) Montg. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bethesda
22. DATE SIGNED: DEC. 10, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/13,67
23c. NAME OF CEMETERY OR CREMATORY: Ash Memorial Cemetery
23d. LOCATION (City or Town) Sandy Spring, (County) Montg., (State) Md.
24. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Maryland
25a. REC'D BY REGISTRAR: DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Juergs

VR A15ME (5) 6M 1/67

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M

17337

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN Hospital: 29 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delbarton
d. STREET ADDRESS: Route #1, Box 191C
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Harold — Middle: (NMN) — Last: Preece, Jr.
4. DATE OF DEATH: Month: December — Day: 26 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 1957 22 September
9. AGE (In years last birthday): 10 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harold Preece, Sr.
14. MOTHER'S MAIDEN NAME: Peggy Sue Runyon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration, Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 Hours
2043
DUE TO
(b) Gastrointestinal Hemorrhage — 24 hours
DUE TO
(c) Acute Lymphocytic Leukemia — 40 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Miliary tuberculosis - inactive.
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 27 November, 19 67, to 26 Dec., 19 67, that I (we) last saw the deceased alive on 26 December, 19 67, and that death occurred at 5:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Richard H. Creech M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: 27 December 1967
22c. PHYSICIAN'S NAME (Type): Richard H. Creech, MD.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 12-28-67
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): Delbarton, W. Va.

24. FUNERAL DIRECTOR: W. W. Chambers Co. Inc — ADDRESS: 1400 Chapin St. NW Wash, D.C.
25a. REC'D BY REGISTRAR — DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

17338

Items 13a,b,c & e Film G396 1/9/68 II

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17337

1. DECEASED-NAME (Type or print): First: Logan; Middle: ; Last: Presler
2a. DATE OF DEATH: Month: December; Day: 20; Year: 1967
2b. HOUR: M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Feb. 8, 1882
6. AGE (In years last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Ohio
7b. CITIZEN OF WHAT COUNTRY?
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Resmor Sanitarium, Grosvenor Lane
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Lawyer- U.S. Gov't.
12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: D.C.
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 5471 Grosvenor Lane — 2213-38th St., NW
14. FATHER'S NAME: First: Hiram; Middle: ; Last: Presler
15. MOTHER'S MAIDEN NAME: First: Mathilde; Middle: ; Last: Herbert
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): - - - (If yes give war or dates of service): - - -
16b. SOCIAL SECURITY NO.: 579-62-6656-T
17. INFORMANT: Capt. Irving Presler — Address: 10861 Springknoll Dr. Potomac, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Bronchial Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 36 hours
DUE TO, OR AS A CONSEQUENCE OF
(b) Senile Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4500

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from June, 1943, to Dec. 20, 1967, that (I) (we) last saw the deceased alive on 12-20 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P.P. Andrews M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 12-20-67
22d. PHYSICIAN'S NAME (Type): P.P. ANDREWS M.D.
22e. ADDRESS: WASHINGTON D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-22-1967
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D.C.
24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE DEC 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Juggs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

17339

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17338

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 10812 Hobson St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-1

70

3. NAME OF DECEASED (Type or print): First: Albert — Middle: E. — Last: Price

4. DATE OF DEATH: Month: 12 — Day: 27 — Year: 1967

5. SEX: M.

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8/6/97

9. AGE (In years lost birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Bro. Retired

10b. KIND OF BUSINESS OR INDUSTRY: — —

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Price

14. MOTHER'S MAIDEN NAME: Hanna Elliott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): WW I Army

16. SOCIAL SECURITY NO.: 578 10 1402

17. INFORMANT: Pamela Price — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) CONGESTIVE HEART FAILURE — 2 yrs
DUE TO
(c) ARTERIOSCLEROTIC HEART DISEASE — 10 yrs

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 10/1, 1963, to 12/27, 1967, that (I) (~~we~~) last saw the deceased alive on 12/27 1967, and that death accurred at 5 pm M, from causes and on the date stated above.

22a. SIGNATURE: John E. Everett — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT

22d. ADDRESS: Kensington, Md. 9400 Conn. Ave

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 12-30-1967

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

23d. LOCATION (City or Town) (County) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR DATE: JAN 3 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Junge

17340

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 72 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Downingtown 75-3
d. STREET ADDRESS: R.D. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: Andrew — Last: Przemyski, Jr.
4. DATE OF DEATH: Month: December — Day: 3 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 23 December 1948
9. AGE (In years last birthday): 18 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): England
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Richard A. Przemyski, Sr.
14. MOTHER'S MAIDEN NAME: Eva Lada
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 183-40-8572
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b) Septicemia with renal and perisplenic abscesses — 2 weeks
DUE TO
(c) Acute myelogenous leukemia — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2043
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral edema (24 hours)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Sept. 22, 1967, to Dec. 3, 1967, that (X) (we) last saw the deceased alive on Dec. 3, 1967, and that death occurred at 10:50 PM, from causes and on the date stated above.

22a. SIGNATURE: David L. Lilien — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 4 December 1967
22c. PHYSICIAN'S NAME (Type): David L. Lilien, MD
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Cemetery
23d. LOCATION (City or Town) (County) (State): Downingtown, Chester, Pa.
24. FUNERAL DIRECTOR: Ralph W. Ralston — ADDRESS: 107 W. Lancaster Ave. Downingtown, Pa. 19335
25a. REC'D BY REGISTRAR — DATE: DEC 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

Release

Hard Copy

Items 18&21 Film 396
12-28-67 ams

1

17341

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17340

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN Ib: 12 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center (N. I. H.)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: New York
b. COUNTY: ---
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 630 E. 93rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel; Middle: (NMN); Last: Rappel

4. DATE OF DEATH: Month: December; Day: 1; Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9 November 1912
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Service
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Rappel
14. MOTHER'S MAIDEN NAME: Ida Meyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1943-45
16. SOCIAL SECURITY NO.: 116-07-7878
17. INFORMANT: The Medical Records, Address: The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac ~~Arrythmia~~ Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(b) Calcific Aortic Stenosis, Post-Operative Aortic Valve Replacement — 6 days
DUE TO
(c) Atherosclerosis — Years

4211

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 19 November 1967, to 1 December 1967, that (X) (we) last saw the deceased alive on 1 December 1967, and that death occurred at 2:15 A.M. from causes and on the date stated above.
2:10 A.M.

22a. SIGNATURE: James C. A. Fuchs
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/1/67
22c. PHYSICIAN'S NAME (Type): James C. A. Fuchs, M. D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-3-67
23c. NAME OF CEMETERY OR CREMATORY: New Mt. Carmel Cemetery
23d. LOCATION (City or Town) (County) (State): Brooklyn New York

24. FUNERAL DIRECTOR: Bernard Danzansky And Sons
ADDRESS: 3501 14th St. N.W. Wash. D.C. 20010
25a. RECD BY REGISTRAR DATE: DEC 4 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17342 17341

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1712 Alberti Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 15-1
d. STREET ADDRESS: 1712 Alberti Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Marie Middle Last Rausch
4. DATE OF DEATH: Month Dec Day 16 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 9, 1875
9. AGE (In years last birthday): 92 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Thomas Podlesak
14. MOTHER'S MAIDEN NAME: Anna Cesal
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 310-05-5666D
17. INFORMANT: Frank C. Rausch Address: 1712 Alberti Drive Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
332x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebro-sclerosis — Undetermined
DUE TO (c): Generalized Arterio-sclerosis — Undetermined
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile Dementia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr 1, 1966, to Dec 16, 1967, that (I) (we) last saw the deceased alive on Dec 4 1967, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: George L Ball
M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 16, 1967
22c. PHYSICIAN'S NAME (Type): George L Ball
22d. ADDRESS: 10620 Georgia Ave Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-Burial
23b. DATE THEREOF: Dec. 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Emblem Cemetery
23d. LOCATION (City, town or county) (State): Elmhurst Illinois
24. FUNERAL DIRECTOR: Clark E. Wisor Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

Medical Examiner Dr Belden Rap filed concerning this death and he authorized this certificate to sign this certificate

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

856-67

1

17343

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17342

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Penn Shop Road Route 3 15-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ralph; Middle: ; Last: Reece
4. DATE OF DEATH: Month: December; Day: 29; Year: 19 67

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 4-17-81
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman Ret
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Newark, New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 195-07-7094-A
17. INFORMANT: Miss Eleanor Reece
Address: 5029 Trindle Rd. Mechanicsburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive gastrointestinal bleeding — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO (b): Recurrent CA of stomach with liver & node metastases — 6 mos
DUE TO (c):
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 30, 1967, to 12/30, 1967, that (I) (we) last saw the deceased alive on 12/28 1967, and that death occurred at 11:00 p M, from causes and on the date stated above.

22a. SIGNATURE: Benne G. Bendler
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-30-67
22c. PHYSICIAN'S NAME (Type): Benne G. Bendler, M. D.
22d. ADDRESS: 10820 Ga. Ave Wheaton Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: Dec. 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
23d. LOCATION (City or Town) (County) (State): Price George, Maryland

24. FUNERAL DIRECTOR: Clark Wisor Clockwerx Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. DATE RECEIVED BY REGISTRAR: JAN 8 1968
DATE
25b. REGISTRAR'S SIGNATURE

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17344

CERTIFICATE OF DEATH

17343

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt #3 Gaithersburg
d. STREET ADDRESS: 12824 Fern Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna Middle: Grace Last: Reed
4. DATE OF DEATH: Month: December Day: 28 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 24 1895
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Registered Nurse
11. BIRTHPLACE (County & State, or foreign country): Maryland —
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry Soper
14. MOTHER'S MAIDEN NAME: Mellie Priscilla White
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-32-9743
17. INFORMANT: Mrs Arnett (daughter), Address: 12824 Fern Drive Gaithersburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Pancreas
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
157X
INTERVAL BETWEEN ONSET AND DEATH: 2 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/8, 1967, to 12/28, 1967, that (I) (we) last saw the deceased alive on 12/28, 1967, and that death occurred at 11:25 PM, from causes and on the date stated above.

22a. SIGNATURE: Robert C. DaDdario M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/29/67
22c. PHYSICIAN'S NAME (Type): ROBERT C. DADDARIO
22d. ADDRESS: 5413 CEDAR LANE BETHESDA

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/2/68
23c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove
23d. LOCATION (City or Town) (County) (State): Herndon Fairfax Va.
24. FUNERAL DIRECTOR: William C. Hilton
ADDRESS: Barnesville, Md.
25a. REC'D BY REGISTRAR DATE: JAN 3 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

8 1

17345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17345

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: WASH DC ~~MARYLAND~~
b. COUNTY: ~~MONTGOMERY~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~SILVER SPRING~~ WASH. DC 473
d. STREET ADDRESS: 3609-Nichols Ave SE ~~2934 KENILWORTH RD.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RALPH Middle A Last REINHART SR.
4. DATE OF DEATH: Month 12 Day 25 Year 1967
5. SEX: male
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-21-95
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retd
10b. KIND OF BUSINESS OR INDUSTRY: Auto Service
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Lawrence J. Reinhart
14. MOTHER'S MAIDEN NAME: Stella E. Watson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WWI (If yes give war or dates of service): 65-17-4-22-19
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ralph A. Reinhart Jr. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Pneumonia
DUE TO (b): Arteriosclerotic Heart
DUE TO (c): Diabetes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200
INTERVAL BETWEEN ONSET AND DEATH: 1 day / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Emphysema
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967 to Dec 25, 1967 that (I) (we) last saw the deceased alive on Dec 25 1967 and that death occurred at 1:10 PM from causes and on the date stated above.

22a. SIGNATURE: John J Curry
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/26/67
22c. PHYSICIAN'S NAME (Type): JOHN J. CURRY
22d. ADDRESS: 70620 Georgia Ave

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-29-1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Washington DC

24. FUNERAL DIRECTOR: Simmons Bros
ADDRESS: Wash DC
Simmons Bros. 1661-Good Hope Rd SE
25a. REC'D BY REGISTRAR DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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17346

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G396 12/20/87 KK

CERTIFICATE OF DEATH

17344

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN Ib: 4 mos. 9 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BETHESDA-SILVER SPRING NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIREAX
d. STREET ADDRESS: 3430 PICKETT RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

83-2

3. NAME OF DECEASED (Type or print): First NAN Middle Lost REKNER
4. DATE OF DEATH: Month DEC Day 5 Year 1967
5. SEX: FE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-9-82
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: William R. Taylor
14. MOTHER'S MAIDEN NAME: Anna Day
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO.: 375-14-6281A
17. INFORMANT: PATIENT'S CHART Address: 8700 JONES MILL RD. CHEVY CHASE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 min
331X
DUE TO (b) Cerebral Arteriosclerosis — 5 yrs
DUE TO (c) Generalized arteriosclerosis — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/67, 19__ to 12/5/67 19__, that (I) (we) last saw the deceased alive on 10/25/67 19__, and that death accurred at 6:10 P.M. from causes and on the date stated above.

22a. SIGNATURE: Henry C. Scruggs MD — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): HENRY C. SCRUGGS MD
22d. ADDRESS: 5413 Cedar Lane Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 12/7/67
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): Nokomis, Ill.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons Inc. ADDRESS: Wash., D.C.
25a. REC'D BY REGISTRAR DATE: DEC 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

Item 2 see Birth Cert.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17347

CERTIFICATE OF DEATH

17346

1. **PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA (RURAL)
c. LENGTH OF STAY IN Ib: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: MD
b. COUNTY: ~~MONTGOMERY~~ c. Mary B
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~BETHESDA (RURAL)~~ Leonardtown 18.2
d. STREET ADDRESS: ~~NAVAL HOSPITAL~~ Park Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First ANDREZ — Middle MONTAG — Last RICE
4. **DATE OF DEATH**: Month DECEMBER — Day 15 — Year 19 67
5. SEX: MALE
6. COLOR OR RACE: NEG
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 15 DEC 67
9. AGE (In years last birthday): – yrs. — IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): SAINT MARY'S md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ELMER M. RICE
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. **INFORMANT** — Address: ALBERTA MARIE RICE PARK AVE LEONARDTOWN MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE BILATERAL ATELECTOSIS — INTERVAL BETWEEN ONSET AND DEATH
762.5
DUE TO (b) PREMATURITY & IMMATURITY
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 15 DEC, 19 67, to 15 DEC, 19 67 that (I) (we) last saw the deceased alive on 15 DEC 19 67, and that death occurred at 1110 PM, from causes and on the date stated above.

22a. SIGNATURE: GP Swartz — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 16 DEC 1967
22c. PHYSICIAN'S NAME (Type): G.P. SWARTZ, LT, MC, USN
22d. ADDRESS: NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Dec. 24, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bethesda Methodist Cemetry
23d. LOCATION (City or Town) (County) (State): Leonardtown Maryland
24. FUNERAL DIRECTOR: Mattingley Funeral Home, Leonardtown, Md — ADDRESS
25a. REC'D BY REGISTRAR — DATE DEC 21 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

7-249778

1

FOR STATE HEALTH DEPT.

17348

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17347

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville 15-1
d. STREET ADDRESS: 12709 Glen Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary Middle: Anne Last: Ricketts
4. DATE OF DEATH: Month: Dec. Day: 24 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 31, 1932
9. AGE (In years lost birthday): 35 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Private
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Sandras Kidd.
14. MOTHER'S MAIDEN NAME: Effie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries - Severe - INTERVAL BETWEEN ONSET AND DEATH: Sudden
825.9
DUE TO
(b): Trauma from Auto Accident -
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour 5:42 p.m. 12/24 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Dawsonville (County) Montgomery (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Bell M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 12/24/67.

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried
23b. DATE THEREOF: 12/28/67
23c. NAME OF CEMETERY OR CREMATORY: Monocacy
23d. LOCATION (City or Town) Beallsville (County) Monty (State) Md
24. FUNERAL DIRECTOR: Ernest C. Gartner ADDRESS: Ernest C. Gartner Gaithersburg Md
25a. REC'D BY REGISTRAR DATE DEC 28 1967
25b. REGISTRAR'S SIGNATURE: Florence Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

17349

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17348

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 108 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Randolph Hills Nursing Home 4011 Randolph Road Wheaton

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 3109 Verona Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Antionette ~~Nettie~~ Middle: C Last: Rodgers
4. DATE OF DEATH: Month 12 Day 29 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-~~XX~~-1889
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? US.
13. FATHER'S NAME: Wilson Robey ~~XXXXXXXX~~
14. MOTHER'S MAIDEN NAME: ~~XXXXXX~~ Susan Barrett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-54-0219
17. INFORMANT: Mrs. Frances E. Haller — Address: 3109 Verona Drive Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1wk
DUE TO (b): Aneurysm of Aorta — 1wk
DUE TO (c): Atherosclerosis of Aorta — 4YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
451 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Vascular Accident, Parkinsonism
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/12, 1967 to 12/29, 1967 that (I) (we) last saw the deceased alive on 12/28 1967, and that death occurred at 3 P M, from causes and on the date stated above.

22a. SIGNATURE: Raymond T. Benack M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/29/67
22c. PHYSICIAN'S NAME (Type): RAYMOND T. BENACK MD
22d. ADDRESS: 4115 Colie Drive, Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 2, 1968
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D.C.
24. FUNERAL DIRECTOR: ~~XXXXXXX~~ Thomas J. Thomas — ADDRESS: 8434 Georgia Ave Walter E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JAN 8 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17350

CERTIFICATE OF DEATH

17350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 5yrs. 5mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Asbury Methodist Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 9811 Hartford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mrs. Mary Middle Alice Last Schneider
4. DATE OF DEATH: Month Dec Day 2 Year 19 67
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 25 1894
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George H. Shimp
14. MOTHER'S MAIDEN NAME: Iva N. Montgomery
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 213-56-7496 T
17. INFORMANT: Methodist Home Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b) Arteriosclerotic heart disease — 2 yrs.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/1/63, 19__ to 12/2/67 19__, that (I) (we) last saw the deceased alive on 11/28/67 19__, and that death occurred at 830 AM, from causes and on the date stated above.

22a. SIGNATURE: Henry C. Scruggs M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/2/67
22c. PHYSICIAN'S NAME (Type): Henry C. Scruggs, M.D.
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-5-67
23c. NAME OF CEMETERY OR CREMATORY: Parkwood
23d. LOCATION (City or Town) (County) (State): Balto Md
24. FUNERAL DIRECTOR: C.F. Evans & Son ADDRESS: 8802 Harford Rd
25a. REC'D BY REGISTRAR DATE: DEC 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17351 **CERTIFICATE OF DEATH** 17351

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 1 yr 5 mo 13 da
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Randolph Hills Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington b. COUNTY: DC.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia. 47-3
d. STREET ADDRESS: 3051 Idaho Ave. NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eleanor Middle: F. Last: Schnoor
4. DATE OF DEATH: Month: Dec Day: 20 Year: 1967

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/6/1887
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Rochester N.Y.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Frank F. Warth
14. MOTHER'S MAIDEN NAME: Mary T. Weigel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 114143748
17. INFORMANT: Randolph Hills Nursing Home's Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: minutes
331X
DUE TO (b) Cerebral Arteriosclerosis — 6 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/7, 1966, to 12/20, 1967, that (I) ~~(we)~~ last saw the deceased alive on 12/20 1967, and that death occurred at 8 A M, from causes and on the date stated above.

22a. SIGNATURE: Raymond T. Benack M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/20/67
22c. PHYSICIAN'S NAME (Type): RAYMOND T. BENACK MD
22d. ADDRESS: 4115 Colie Drive, Wheaton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: Holy Sepulchre Cem.
23d. LOCATION (City or Town) (County) (State): Rochester, New York.

24. FUNERAL DIRECTOR: H. Lon. DeVol ADDRESS: 2222 Wis. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

17352

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17352

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b: 1 day

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: A A 2

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Anapolis, Junction (Anapolis) 02-2

d. STREET ADDRESS: Box 46

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Hugo — Middle: Herman — Last: Schwarz

4. DATE OF DEATH: Month: December — Day: 22 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-26-98

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Carl Schwarz

14. MOTHER'S MAIDEN NAME: Teresa Knitzinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~yes~~ No (If yes give war or dates of service): German Navy

16. SOCIAL SECURITY NO.:

17. INFORMANT: Patient's chart — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic bronchitis, emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19 65, to Dec. 22, 19 67, that (I) (we) last saw the deceased alive on Dec. 22 1967, and that death occurred at 9:31 P.M., from causes and on the date stated above.

22a. SIGNATURE: A W Danish — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec. 23, 1967

22c. PHYSICIAN'S NAME (Type): ABRAHAM W. DANISH

22d. ADDRESS: 1106 SPRING ST. S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 12/23/67

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Crematory

23d. LOCATION (City or Town) (County) (State): Prince G Md.

24. FUNERAL DIRECTOR: Arthur Peters — ADDRESS: 556 Wash Blvd Laurel, Md.

25a. REC'D BY REGISTRAR DATE DEC 27 1967

25b. REGISTRAR'S SIGNATURE: Frances Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17353

CERTIFICATE OF DEATH

17353

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 34 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington, D.C.
b. COUNTY: MARYLAND
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 1600 16th Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

473

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: (NMN); Last: Scrippens
4. DATE OF DEATH: Month: December; Day: 23; Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 19 March 1925
9. AGE (In years last birthday): 42 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photo Lithographer
10b. KIND OF BUSINESS OR INDUSTRY: Lithographic Co.
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Michael Scrippens
14. MOTHER'S MAIDEN NAME: Anna Kohan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1943-45
16. SOCIAL SECURITY NO.: 199-14-3960
17. INFORMANT: The Medical Records; Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		Interval between onset and death
IMMEDIATE CAUSE (a)	Myocardial Infarction	2 days
DUE TO (b)	Aortic Insufficiency	12 years
DUE TO (c)	Rheumatic Valve Disease	20 years

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 8 days following open heart surgery for aortic valve replacement.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (☒ (this hospital) attended the deceased from 19 November 19 67, to 23 Dec., 19 67, that (☒ (we) last saw the deceased alive on 23 December 19 67, and that death occurred at 10:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Eric H. Johnson
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1967 23 December
22c. PHYSICIAN'S NAME (Type): Eric H. Johnson, MD
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-27-67
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's G. C. Cem.
23d. LOCATION (City or Town) (County) (State): Pringle, Penna
24. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS
25a. REC'D BY REGISTRAR DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

17354

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17354

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN. & HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 717 BAYFIELD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle BEALE Last SEEK
4. DATE OF DEATH: Month 12 Day 4 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-9-97
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: RICHARD SEEK
14. MOTHER'S MAIDEN NAME: ISABEL COLE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-22-8604
17. INFORMANT: MAY SEEK - NIECE — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Arteriosclerotic Heart Disease
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, town or county): Wheaton
22. DATE SIGNED: DEC. 4, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Colesville Cemetery
23d. LOCATION (City or Town) (County) (State): Colesville, Maryland
24. FUNERAL DIRECTOR: WARNER-PUMPHREY INC. — John B. Thomas
ADDRESS: 8434 Georgia Avenue, Silver Spring, Maryland
25a. REC'D BY REGISTRAR: DATE DEC 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge — Dec. 5, 1967

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17355 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 17355

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 18 days/18 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 501 Sligo Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Kimberly Middle Ruth Last Seek

4. DATE OF DEATH: Month 12 Day 20 Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-17-61
9. AGE (In years last birthday): 6 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: school
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore Seek
14. MOTHER'S MAIDEN NAME: Pauline ~~Seek~~ VANCE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Theodore Seek Address: Hospital Records 2d.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Toxic Reaction to Conflagration
DUE TO (b): Burns of 65% of Body
DUE TO (c): Surface
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Deceased playing with electric stove and clothing caught fire
20c. TIME OF INJURY Month, Day, Year: 10:30 a.m. 12-2 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME
20f. (City or town) SILVER SPRING (County) MONTGOM. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BELDEN R. REAP M.D. Address (Street, city, town, or county): Wheaton
22. DATE SIGNED: DEC. 21, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/23/1967
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter ADDRESS: 8434 Ga. Ave
Warner E. Pumphrey, Inc. Silver Spring, Md

25a. REC'D BY REGISTRAR DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME
3500 4-64

1

17356

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17356

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ~~MONTGOMERY~~ ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELLICOTT CITY
d. STREET ADDRESS: RT. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

13-2

3. NAME OF DECEASED (Type or print): First VIOLA Middle RACHEL Last SELBY
4. DATE OF DEATH: Month DECEMBER Day 2 Year 19 67
5. SEX: FEMALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-16-01
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ZETTA EASTON
14. MOTHER'S MAIDEN NAME: MINNIE MUSGROVE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): UNKNOWN (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 217-34-5282
17. INFORMANT: MEDICAL RECORDS Address: MONT. GEN. HOSP. OLNEY MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) TOXEMIA-SEPTISEMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
DUE TO (b) PANCREATIC ABSCESS — WKS —
DUE TO (c) PANCREATITIS NECROTIC — 8-12 WKS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5870
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): INFARCTION TERMINAL ILEUM - DUE TO ADHESIONS
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AUGUST, 1967 to DEC 2, 1967, that (I) (we) last saw the deceased alive on DEC 2 1967, and that death occurred at 8 45 A M, from causes and on the date stated above.

22a. SIGNATURE: Donald F. Jones M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: DEC 2, 1967
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-5-67
23c. NAME OF CEMETERY OR CREMATORY: CRESTLAWN
23d. LOCATION (City or Town) (County) (State): N. FRIENDSHIP MD.
24. FUNERAL DIRECTOR: Higinbotham-Slack
ADDRESS: ELLICOTT CITY MD
25a. REC'D BY REGISTRAR DATE DEC 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Juggs

VR A15 (4)
25M 1/67

69

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17357 17357

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitorium.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE MD b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 15.1
d. STREET ADDRESS Carroll Hall Sanitorium 10231 Carroll Place
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Frances Middle D. Last Shafer
4. DATE OF DEATH Month December Day 22 Year 1967
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov. 7, 1874
9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (County & State, or foreign country) Cleveland Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jay P. Dawley
14. MOTHER'S MAIDEN NAME Iva Gissela Canfield
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service) None
16. SOCIAL SECURITY NO. 286-24-6832D
17. INFORMANT Col. Henry L. Shafer - Wash. D.C. Address 5454 Nebraska Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 15 minutes
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease —
DUE TO (c) Generalized Arteriosclerosis —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May 1, 1967, to Dec. 22, 1967, that (I) (~~we~~) last saw the deceased alive on Dec. 22 1967, and that death occurred at 10:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE Henry M. Lowden M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 12/23/67.
22c. PHYSICIAN'S NAME (Type) Henry M. Lowden
22d. ADDRESS 5206 Norway Av., Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b. DATE THEREOF 12/23/1967
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory
23d. LOCATION (City, town or county) (State) Colmar Manor Prince Geo. Co. MD
24. FUNERAL DIRECTOR W.W. Chambers Co. ADDRESS Washington DC
25a. REC'D BY REGISTRAR DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

8

1

17358

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17358

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 48 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Fayette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Connellsville
d. STREET ADDRESS: 1122 Sycamore Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sara — Middle: A. — Last: Shartzer
4. DATE OF DEATH: Month: Dec. — Day: 6 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-5-95
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Issac Morgan
14. MOTHER'S MAIDEN NAME: Ida May Docherty
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 182-36-3908
17. INFORMANT: Mrs. John E. Grubb — Address: 705 Winnall Way, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL ARTERIAL SCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH
334 X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 19, 1967, to Dec 6, 1967, that (I) (we) last saw the deceased alive on Dec 6 1967, and that death occurred at 2:35 P M, from causes and on the date stated above.

22a. SIGNATURE: Jonathan M. Williams — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec-6-67
22c. PHYSICIAN'S NAME (Type): Jonathan M. Williams
22d. ADDRESS: 808 Pershing Dr. Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial
23b. DATE THEREOF: Dec. 8th 1967
23c. NAME OF CEMETERY OR CREMATORY: Greenridge Memorial Park
23d. LOCATION (City or Town) (County) (State): Connelsville, Penna.
24. FUNERAL DIRECTOR: C. Glen Carter — ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.
Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR — DATE: DEC 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Items 18&21 Film 396 12-2

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17359

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17359

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.
c. LENGTH OF STAY IN Ib 7Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 4207 East WestHighway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16-2

3. NAME OF DECEASED (Type or print) First Ralph Middle J. Last Sheffer
4. DATE OF DEATH Month 12 Day 6 Year 1967
5. SEX male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 6/12/90
9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. P. A.
10b. KIND OF BUSINESS OR INDUSTRY self employed
11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Eddy Sheffer
14. MOTHER'S MAIDEN NAME Myrtie Maxon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) W W 1
16. SOCIAL SECURITY NO. 577-40-6850
17. INFORMANT Charlotte M. Sheffer Address Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute massive intracerebral hemorrhage
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) BELDEN R. REAP M.D. Address (Street, city, town, or county) Wheaton
22. DATE SIGNED DEC. 6, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Dec 9, 1967
23c. NAME OF CEMETERY OR ~~CREMATORY~~ Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE DEC 11 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

17360

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): — 3907 WARNER ST.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3907 Warner St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: D — Last: Sheldon
4. DATE OF DEATH: Month: Dec. — Day: 30 — Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/6/05
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Queens County, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: James G. DeBebaise
14. MOTHER'S MAIDEN NAME: Catherine MacLardy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-46-2918
17. INFORMANT: Husband — Address: James Sheldon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO (b): Glioblastoma
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1939
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. None 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/15, 1967, to present, 19__, that (I) (we) last saw the deceased alive on 12/29 1967, and that death occurred at 3:15 PM, from causes and on the date stated above.

22a. SIGNATURE: John B. Umhau M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/30/67
22c. PHYSICIAN'S NAME (Type): JOHN B. UMHAU MD
22d. ADDRESS: 8805 Conn. Ave. Chevy Chase Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4 Jan 1968
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville Mont Md.

24. FUNERAL DIRECTOR: Robert A Pumphrey — ADDRESS: 7557 Wisconsin Ave Bethesda, Md
25a. REC'D BY REGISTRAR — DATE: JAN 5 1968
25b. REGISTRAR'S SIGNATURE: Charles Gaige

VR A15 (4)
25M 1/67

10 1

FOR STATE HEALTH DEPT.

M 1

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17361

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. Boyds.
c. LENGTH OF STAY IN 1b: 54 yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 17 B.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (R) Boyds-
d. STREET ADDRESS: Box 17. B.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

15-1

3. NAME OF DECEASED (Type or print): First: William Arthur. Middle: Arthur. Last: Shiflet
4. DATE OF DEATH: Month: Dec- Day: 8 Year: 1967

5. SEX: M.
6. COLOR OR RACE: W-
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 7, 1913
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gen'l ~~Gens. Engineer~~ Superintendent
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Elijah. Shiflet
14. MOTHER'S MAIDEN NAME: Virginia. Fauver.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 284-07-6346
17. INFORMANT: Mrs. Margaret Simpson Shiflet, Address: Boyds, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficency Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4201
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
22. DATE SIGNED: 12/9/67.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 13 Dec. 67
23c. NAME OF CEMETERY OR CREMATORY: Mount Comfort Cemetery
23d. LOCATION (City or Town) (County) (State): Fairfax Co., Virginia

24. FUNERAL DIRECTOR: B. Earle Mountcastle ADDRESS: Cunningham-Mountcastle Funeral Home, Woodbridge, Va.
25a. REC'D BY REGISTRAR DATE: DEC 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

17362

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17362

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 14 yr. 4 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Maryland 15,
d. STREET ADDRESS: 5 Burket Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jesse Middle: Ashby Last: Shives

4. DATE OF DEATH Month: Dec. Day: 22, Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 2-26-1879
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gas Station Owner
10b. KIND OF BUSINESS OR INDUSTRY: Gas Station
11. BIRTHPLACE (County & State, or foreign country): Hancock, Md.
12. CITIZEN OF WHAT COUNTRY?: Amer

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-26-8539A
17. INFORMANT: Dorothy Garner Address: 5 Burket Court Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Flu Syndrome - General Debility
DUE TO (b): ac Cvd.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
481X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diverticulitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May, 1967, to Dec 22, 1967, that (I) (we) last saw the deceased alive on Dec. 18 1967, and that death occurred at 11:30 P M, from causes and on the date stated above.

22a. SIGNATURE: Russell C. Bufalino M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 22, 1967
22c. PHYSICIAN'S NAME (Type): RUSSELL C. BUFALINO
22d. ADDRESS: 1429 University Blvd W.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: John B. Thomas John B. Thomas
Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17363 Item 9 Film G396 1/5/68 kk 17363

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: WASH.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown. Md. 21,2
d. STREET ADDRESS: ROUTE # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARTHA Middle: JANE Last: SHIVES
4. DATE OF DEATH: Month: DEC. Day: 14 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2.11.1879
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON COUNTY MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: ELIZABETH BAKER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS LEO YOUNKER RURAL 2 HANCOCK MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO (b) Bronchopneumonia — 2 days
DUE TO (c) advanced senility — 1 yr.

491 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this ~~hospital~~) attended the deceased from Aug, 1967 to Dec 14, 1967, that I (we) last saw the deceased alive on Dec 14 1967, and that death occurred at 10P M, from causes and on the date stated above.

22a. SIGNATURE: Marvin Wadler M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/14/67
22c. PHYSICIAN'S NAME (Type): MARVIN WADLER
22d. ADDRESS: 8218 Wisc. Av. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12.17.67
23c. NAME OF CEMETERY OR CREMATORY: ORCHARD RIDGE
23d. LOCATION (City or Town) (County) (State): RURAL HANCOCK WASHINGTON MD
24. FUNERAL DIRECTOR: Howard H. Lane Hancock md — ADDRESS
25a. REC'D BY REGISTRAR DATE DEC 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17364

CERTIFICATE OF DEATH

17364

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church
d. STREET ADDRESS: 6030 Vista Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: James — Last: Shugars
4. DATE OF DEATH: Month: December — Day: 3 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Caus.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/22/1889
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Engineer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Louden County, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Shugars
14. MOTHER'S MAIDEN NAME: Cassandrew Stoneburner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 577-10-0399
17. INFORMANT: Delia H. Shugars — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
334X
IMMEDIATE CAUSE (a) Respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH: 45 mins
DUE TO
(b) Arteriosclerotic cerebrovascular disease 6 mos
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from OCT 11, 1967 to DEC 3, 1967 that (I) (~~we~~) last saw the ~~deceased alive~~ on 3 DEC 1967, and that death occurred at 3:45 p.m., from causes and on the date stated above.

22a. SIGNATURE: Walter Goorh
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/3/67
22c. PHYSICIAN'S NAME (Type): WALTER GOORH MD
22d. ADDRESS: 2304 SHOREFIELD RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: Dec. 6. 1967
23c. NAME OF CEMETERY OR CREMATORY: Culpeper National
23d. LOCATION (City or Town) (County) (State): Culpeper, Virginia

24. FUNERAL DIRECTOR: Jackie L Bugg — ADDRESS: Ives Funeral Home
25a. REC'D BY REGISTRAR: DEC 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17365

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17365

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 734 College Pkwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Brian — Middle: Michael — Last: Shulman

4. DATE OF DEATH: Month: Dec — Day: 22 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: Nov 26 1966
9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Barry Shulman
14. MOTHER'S MAIDEN NAME: Myrna Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mother — Address: Same as above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Aspiration of food.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Sudden

9210

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated piece of apple during eating
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m.: 10 a.m. 12/22 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home.
20f. (City or town): Rockville (County): Montgomery (State): Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): John S. Ball M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 12/22/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/24/67
23c. NAME OF CEMETERY OR CREMATORY: HOATH ISRAEL Cem.
23d. LOCATION (City or Town) (County) (State): TRENTON. NJ.

24. FUNERAL DIRECTOR: Goldberg Funeral Home
ADDRESS: 4217-9th Ave.
25a. REC'D BY REGISTRAR DATE DEC 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

4

1

17366

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 6 & 7 Film G396 1/3/68 kk

CERTIFICATE OF DEATH

17366

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Bethesda~~ Bethesda
c. LENGTH OF STAY IN 1b: 1yr 3 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bethesda-Silver Spring Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 9906 East Bexhill Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-1

90

3. NAME OF DECEASED (Type or print): First: Edith — Middle: — Last: Sibert
4. DATE OF DEATH: Month: 12 — Day: 21 — Year: 1967
5. SEX: Femple
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 30, 1896
9. AGE (In years lost birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (County & State, or foreign country): West Virginia.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Van Shelby Perkins
14. MOTHER'S MAIDEN NAME: Frances Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 403-01-8586 D
17. INFORMANT: Boyd Sibert — Address: See Item No. 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
332x
IMMEDIATE CAUSE (a): Cerebral Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(b): Cerebral Artery Sclerosis — years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

3

21. I certify that (I) (this hospital) attended the deceased from July 4, 1962 to Dec 21, 1967, that (I) (we) last saw the deceased alive on Dec 15 1967, and that death occurred at 2:00 p.m., from causes and on the date stated above.

22a. SIGNATURE: Robert B. Harell — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Robert B. Harell MD
22d. ADDRESS: 5516 Nebraska Ave DC.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-26-1967
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery
23d. LOCATION (City or Town) (County) (State): Arlington, Va.
24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

17367

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Item #2a,b,c & d Film#G396 12/20/67 ph

Item #23b Film #G396 12/20/67 ph

17367

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING MD.
c. LENGTH OF STAY IN 1b: 15.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DELLA VISTA NURSING HOME.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10430 Brookmore Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: RILLA Middle: MAE HAUKE Last: SKINNER.

4. DATE OF DEATH: Month: Dec. Day: 6 Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Sept 10, 1889

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Federal Govt - Retired

10b. KIND OF BUSINESS OR INDUSTRY: Federal Govt

11. BIRTHPLACE (County & State, or foreign country): Tacoma, Washington

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Charles Hauke

14. MOTHER'S MAIDEN NAME: Carrie Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS NAOMI SULLIVAN Address: 10430 BROOKMOOR DR. S.S. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
442X
DUE TO (b): Cardio-Vascular Renal Disease — 1 Yr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/16, 1967, to 12/6, 1967, that (I) (we) last saw the deceased alive on 12/4 1967, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Harold Hedges

M.O. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/6/67

22c. PHYSICIAN'S NAME (Type): Harold Hedges

22d. ADDRESS: 5415 Conn Ave NW DC

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: Dec 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION (City, town or county) (State): Washington D.C.

24. FUNERAL DIRECTOR: Arthur Walters

ADDRESS: 254 Carroll St. N.W. D.C.

25a. REC'D BY REGISTRAR DATE DEC 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17368

CERTIFICATE OF DEATH

17368

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 56 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: (PR. GEO)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
d. STREET ADDRESS: 4513 Rena Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank; Middle: Kane; Last: SLASON
4. DATE OF DEATH: Month: December; Day: 31; Year: 19 67
5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1913
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Capt. USN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Staten Island, New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John A. Slason
14. MOTHER'S MAIDEN NAME: Elizabeth Kane
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 561 54 3644
17. INFORMANT: Apt. 409, Chevy Chase, Md. Miss Helen B. Schumann, 5100 Dorset Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis of Liver
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

5810

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Nov. 5, 1967, to Dec. 31, 1967, that ☒ (we) last saw the deceased alive on Dec. 31 19 67, and that death occurred at 1145A M, from causes and on the date stated above.

22a. SIGNATURE: Frank C. Blackburn M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: Jan. 2, 1968
22c. PHYSICIAN'S NAME (Type): Frank C. Blackburn, M. D.
22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/4/68
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia
24. FUNERAL DIRECTOR: Falls Church Funeral Home
ADDRESS: 1102 W. Broad St., Falls Church, Virginia
25a. REC'D BY REGISTRAR DATE: JAN 8 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

17369

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17369

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 97 days (9/4/67 12-11-67)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 4512 HARLING LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

151

3. NAME OF DECEASED (Type or print): First: MARJORIE Middle: M. Last: SLOTHOWER
4. DATE OF DEATH: Month: DEC Day: 11 Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-28-99
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Turck
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 577-54-2634
17. INFORMANT: Son — John H. Slothower Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis with intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b) Primary carcinoma of ovary — 12 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1750
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN, 19 56, to DEC, 19 67, that (I) (we) last saw the deceased alive on DEC 10 1967, and that death occurred at 4:00 P.M., from causes and on the date stated above.

22a. SIGNATURE: L. J. Donovan M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/11/67
22c. PHYSICIAN'S NAME (Type): DR LEO I DONOVAN
22d. ADDRESS: 8218 WISCONSIN AVE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-14-67
23c. NAME OF CEMETERY OR CREMATORY: Warrington Quaker Cem.
23d. LOCATION (City or Town) (County) (State): Wellsville, Penna.
24. FUNERAL DIRECTOR: Robert A. Pumphrey, ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Filed by Dr. Belden Roy Hoffman

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17370 17370

CERTIFICATE OF DEATH

*Also knownas EVA ELORA SCHMITZ.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 36 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SYLVAN MANOR HEALTH CARE CENTER

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD.
b. COUNTY: ~~MONTGOMERY~~ PRINCE GEO 16.2
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~SILVER SPRING~~ TAKOMA PARK
d. STREET ADDRESS: 902 JACKSON AVE ~~2700 PARKER ST~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): a/k/a Eva Elora Schmitz — First: EVA Middle: ELORA Last: SMITH*

4. DATE OF DEATH: Month: DEC. Day: 16 Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/10/1872
9. AGE (In years last birthday): 95 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Butler
14. MOTHER'S MAIDEN NAME: Not available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Frank C. Kluge (same as #2) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis Generalized — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
450.0
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July, 1958 to 12-16, 1967 that (I) (we) last saw the deceased alive on 11.28 1967, and that death occurred at 1:01 M, from causes and on the date stated above.

22a. SIGNATURE: James H. Rudolph M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-16-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 7717 Carroll Ave Takoma Park

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 19. 1967
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Memorial Park
23d. LOCATION (City or Town) (County) (State): Portsmouth Va.

24. FUNERAL DIRECTOR: Arthur Walters
ADDRESS: 254 Carroll St. N.W. Washington, D.C. 20012

25a. REC'D BY REGISTRAR DATE DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

3
4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17371 **CERTIFICATE OF DEATH** 17371

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 4311 Independence St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MADELINE Middle: E. Last: Smith
4. DATE OF DEATH: Month: Dec. Day: 11 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/26/1898
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Government Emp.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William B. Rudy
14. MOTHER'S MAIDEN NAME: Alvaretta Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-12-6893
17. INFORMANT: daughter Arline Smith Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypostatic bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b)
DUE TO (c)
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.
491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/3/67, 19__ to 12/11/67, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at 12:46 AM, from causes and on the date stated above.

22a. SIGNATURE: Jay R Shapiro M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/11/67
22c. PHYSICIAN'S NAME (Type): J. R. Shapiro
22d. ADDRESS: 8218 Wisconsin Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 12/13/67
23c. NAME OF CEMETERY OR CREMATORY: Mifflinburg
23d. LOCATION (City or Town) (County) (State): Mifflinburg, Pa.

24. FUNERAL DIRECTOR: Tyson Wheeler ADDRESS: 1331 Rockville Pike Rockville, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

17372

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17372

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 9405 AVENEL ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

68

3. NAME OF DECEASED (Type or print): First OLIVER Middle James Last SMITH
4. DATE OF DEATH: Month DEC Day 27 Year 1967
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/1/95
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Agent
10b. KIND OF BUSINESS OR INDUSTRY: Internal Revenue
11. BIRTHPLACE (County & State, or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Major D. Smith
14. MOTHER'S MAIDEN NAME: Sarah Singelton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-38-4440
17. INFORMANT: A Eva M. Smith Address: 9405 Avenel Road Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cerebral vasular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
331X
DUE TO (b) Generalized arteriosclerosis — Several years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 23, 1967, to December 27, 1967, that (I) (we) last saw the deceased alive on December 26 1967, and that death occurred at 3:30 A M, from causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 27, 1967
22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr. M.D.
22d. ADDRESS: 9301 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges Co. Md.
24. FUNERAL DIRECTOR: Glen C. Glen Carter ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR DATE JAN 4 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (a) 25M 1/67

FOR STATE HEALTH DEPT.

17373

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17373

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo 15-1
d. STREET ADDRESS: 6103 Princeton Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Edward Last: Smith
4. DATE OF DEATH: Month: Dec. Day: 18 Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 11, 1909
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Robert Edward Smith Sr.
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-03-5133
17. INFORMANT: Catherine E. Smith - wife — Address: Add zone.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute — INTERVAL BETWEEN ONSET AND DEATH: 4 m.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 12/18/67
EXAMINER'S NAME (Type): JOHN G. BALL
Address (Street, city, town, or county): Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-20-67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince George County, Md.
24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, Bethesda, Maryland — ADDRESS
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17374

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 11 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa Nursing Home 12325 New Hampshire Ave., Sil. Sp., Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 37 Philadelphia Ave, Takoma Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle GOLDEN Last SPRINGMANN
4. DATE OF DEATH: Month Dec. Day 22 Year 1967
5. SEX: F
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-12-85
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (County & State, or foreign country): BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: CHARLES REANEY
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-56-8935-7
17. INFORMANT: Nursing Home Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — 17 YEARS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Nov, 1960, to Dec, 1967, that (I) (~~we~~) last saw the deceased alive on 12-15 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Henry R. Wolfe M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/22/1967
22c. PHYSICIAN'S NAME (Type): H R WOLFE
22d. ADDRESS: 905 Sheridan St Hyattsville 20783

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec 26, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Suitland Prince Geo Md
24. FUNERAL DIRECTOR: J. Arthur Walters ADDRESS: 254 Carroll Street N.W. Washington, D.C. 20012
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR 415 (4) 20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17375

CERTIFICATE OF DEATH

17376

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 50 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1908 GLENALLEN AVE.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1908 Glen Allen Ave.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Paul, Middle: , Last: Stadler
4. DATE OF DEATH: Month 12, Day 4, Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 18 1898
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-employed
10b. KIND OF BUSINESS OR INDUSTRY: Nursery
11. BIRTHPLACE (County & State, or foreign country): Switzerland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Henrich Stadler
14. MOTHER'S MAIDEN NAME: Bertha Eichenberger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-46-1967
17. INFORMANT: Mrs R. Stadler Address: 1908 Glenallen S.S. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 177X
DUE TO (b): Adenocarcinoma Prostate & Genitourinary
DUE TO (c): Bladder Obstruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2/15/67. unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Tumor growth involving also Pelvis + at Hip area
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/15, 1966, to 12/4, 1967, that (I) (we) last saw the deceased alive on 11/28 1967, and that death occurred at 7:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Howard T. Morse M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/4/67
22c. PHYSICIAN'S NAME (Type): Howard T Morse
22d. ADDRESS: 7630 Carroll Ave Takoma Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 6, 1967
23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
23d. LOCATION (City or Town) (County) (State): McConnelsburg, Penna.
24. FUNERAL DIRECTOR: C. Glen Carter ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR DATE: DEC 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

16

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17376 **CERTIFICATE OF DEATH** 17377

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 15-1
d. STREET ADDRESS: 9706 Pisgah Rd. MT.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

68

3. NAME OF DECEASED (Type or print): First: DORAN Middle: (NMI) Last: STARKEY
4. DATE OF DEATH: Month: 12 Day: 8 Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-31-21
9. AGE (In years last birthday): 46 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLASSIFIED
10b. KIND OF BUSINESS OR INDUSTRY: DEPT. DEFENSE
11. BIRTHPLACE (County & State, or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: GEORGE B. STARKEY
14. MOTHER'S MAIDEN NAME: HELEN PHILLIPS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WWII AND KOREAN
16. SOCIAL SECURITY NO.: 163-18-2438
17. **INFORMANT**: PETER EDIVAN Address: 2403 COOL SPRING RD, ADELPHI MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a): CIRCULATORY COLLAPSE (SHOCK)
4201
DUE TO (b): CORONARY THROMBOSIS - MYOCARDIAL INFARCTION — 10-11 HOURS
DUE TO (c): ARTERIOSCLEROTIC HEART DISEASE — CIRCA 5-6 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CHRONIC CHOLECYSTITIS WITH CHOLELITHIASIS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from NOV., 19 66, to 12/8, 19 67, that (I) (we) last saw the deceased alive on 12/8 19 67, and that death occurred at 1:35 A.M., from causes and on the date stated above.

22a. SIGNATURE: Lawrence D. Marcus M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): LAWRENCE D. MARCUS, MD
22d. ADDRESS: 1111 SPRING STREET, SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11 DEC. 1967
23c. NAME OF CEMETERY OR CREMATORY: GERMAN LUTHERAN CEMETERY
23d. LOCATION (City or Town) (County) (State): MAHANOY CITY PA.

24. FUNERAL DIRECTOR: RINALDI FUNERAL HOME ADDRESS: 7400 GEORGIA AVE. N.W. DC 20012
25a. REC'D BY REGISTRAR DATE DEC 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

17377
Item #2 Film #G397 1/24/68 a

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17378

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sylvan Manor Health Care Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD D. C. — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING — Washington
d. STREET ADDRESS: 1028 Conn. Ave. NW — Stoneleigh Apts
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BLANCHE — Middle: W. — Last: STEEVER
4. DATE OF DEATH: Month: 12 — Day: 31 — Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-28-1882
9. AGE (In years lost birthday): 85 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): N/A
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Alonzo M. L.
14. MOTHER'S MAIDEN NAME: Jennie (Maiden name unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 325-09-3705
17. INFORMANT: Watson Andrews — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA OF COLON — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
1538
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): RECENT FEBRILE RESPIRATORY DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from _____, 1962, to DEC 31, 1967, that (I) (we) last saw the deceased alive on DEC 31 1967, and that death occurred at 2:40 P.M. from causes and on the date stated above.

22a. SIGNATURE: Edward A. Beeman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: DEC 31, 1967
22c. PHYSICIAN'S NAME (Type): EDWARD A. BEEMAN
22d. ADDRESS: 1015 SPRING ST. SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 5, 1968
23c. NAME OF CEMETERY OR CREMATORY: Spring Grove Cemetery
23d. LOCATION (City or Town) (County) (State): Cincinnati, Ohio
24. FUNERAL DIRECTOR: J. J. Murphy — ADDRESS: Murphy Funeral Home. Arlington, Virginia
25a. REC'D BY REGISTRAR DATE JAN 8 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

17378

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film G396 1/12/68 kk

CERTIFICATE OF DEATH

17379

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 10 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG
d. STREET ADDRESS: 6 WEST DEER PARK DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-1

3. NAME OF DECEASED (Type or print): First: BABY — Middle: GIRL — Last: STEVENS
4. DATE OF DEATH: Month: December — Day: 28 — Year: 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 28, 1967
9. AGE (In years last birthday): NB yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 10 / Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MONTGOMERY-CTY, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ALBERT STEVENS
14. MOTHER'S MAIDEN NAME: BERTHA S. LINGER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MEDICAL RECORDS-MONTGOMERY GEN. HOSP. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 10 hr
DUE TO (b) Congenital atelectasis — 10 hr
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7620

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/28, 19 67, to ____, 19__, that (I) (we) last saw the deceased alive on 12/28 19 67, and that death occurred at 11:45 AM, from causes and on the date stated above.

22a. SIGNATURE: C. H. Ligon, M.D.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/29/67
22c. PHYSICIAN'S NAME (Type): C. H. LIGON, M.D.
22d. ADDRESS: MEDICAL CENTER, SANDY SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-30-67
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak
23d. LOCATION (City or Town) (County) (State): Gaithersburg, Montg. Md.

24. FUNERAL DIRECTOR: Ernest C. Gardner — ADDRESS: Gaithersburg Md.
25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

7-274-418

VR A15 (A)
25M 1/67

8

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17379

CERTIFICATE OF DEATH

17380

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dunbar
d. STREET ADDRESS: 308½ 11th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

85-3

26

3. NAME OF DECEASED (Type or print): First: Van Cleve — Middle: — Last: STILTNER

4. DATE OF DEATH: Month: December — Day: 10 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 20, 1913

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Stiltner

14. MOTHER'S MAIDEN NAME: Grace Monohan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): 1931-1953

16. SOCIAL SECURITY NO.: 233-56-9592

17. INFORMANT: Dunbar — Address: W. Va.
Mrs. Virginia Stiltner, 308½ 11th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Encephalomalacia of left temporal parietal area
DUE TO (b): massive Hypertensive cardiovascular disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X
INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 6, 19 67, to Dec. 10, 19 67, that (I) (we) last saw the deceased alive on Dec. 10 19 67, and that death occurred at 1 45 P M, from causes and on the date stated above.

22a. SIGNATURE: Charles S. Reeves — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: Dec. 11, 1967

22c. PHYSICIAN'S NAME (Type): Charles S. Reeves, M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-13-67

23c. NAME OF CEMETERY OR CREMATORY: Roselawn Gardens

23d. LOCATION (City or Town) (County) (State): Princeton, W.Virginia

24. FUNERAL DIRECTOR: Falls Church Funeral Home — **ADDRESS**: 1102 West Broad St., Falls Church, Va.

25a. REC'D BY REGISTRAR — DATE: DEC 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

17380

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17381

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland (Dist. of Col.) b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville, Maryland (Washington)
d. STREET ADDRESS: 1660 Lanier Place N.W. ~~4600 Harlan Street~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Irene — Middle: E. — Last: Stinemetz

4. DATE OF DEATH: Month: December — Day: 16 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 18, 1889
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Auditor
10b. KIND OF BUSINESS OR INDUSTRY: G.A.O.
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel W. Stinemetz
14. MOTHER'S MAIDEN NAME: Elizabeth Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: William H. Alexander — Address: 1660 Lanier Pl. N.W.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia & Cong Heart failure
DUE TO (b) accord
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 20, 1967, to Dec. 14, 1967, that (I) (we) last saw the deceased alive on Dec. 15 1967, and that death occurred at A M, from causes and on the date stated above.

22a. SIGNATURE: Russell C Bufalino, M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 16, 1967
22c. PHYSICIAN'S NAME (Type): Russell C Bufalino M.D.
22d. ADDRESS: 1429 University Blvd W. Sil. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-19-1967
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D.C.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Washington, D.C.
25a. REC'D BY REGISTRAR — DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

Items 18-21 Film 396
1-15-68 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17381

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17382

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney (rural)
c. LENGTH OF STAY IN 1b: P. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 17715 Cashell Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PEARL — Middle: MARIE — Last: STONER

4. DATE OF DEATH: Month: DEC. — Day: 16 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/25/18
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Calvin Dunfee
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Twila Stoner Hirlinger — Address: 7528 Sweet Briar College Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia due to smoke inhalation during — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): house fire
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Deceased asleep when house caught fire
20c. TIME OF INJURY Month, Day, Year: 12-16 1967 — Hour a.m. p.m. 12.30
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Rockville — (County): Montg. — (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Read M.D.
EXAMINER'S NAME (Type): BELDEN R. READ M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 2[illegible]
22. DATE SIGNED: DEC. 16, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 12/19/1967
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CREMATORY
23d. LOCATION (City or Town) (County) (State): GILMAR MANOR PRGES CO. MD.

24. FUNERAL DIRECTOR: W. W. CHAMBERS, INC. — ADDRESS: SILVER SPRING, MD
25a. REC'D BY REGISTRAR: DATE DEC 21 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15ME (5)
6M 1/67

1

17382

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17383

1. PLACE OF DEATH
a. COUNTY: Mont.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN Tb: 3 Mos. 28 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4322 Leland St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15.1

3. NAME OF DECEASED (Type or print): First: Lallie; Middle: A; Last: Street
4. DATE OF DEATH: Month: 12; Day: 27; Year: 19 67
5. SEX: Female
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-27-75
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: John Abergronbie
14. MOTHER'S MAIDEN NAME: Laura Martin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220-44-1774
17. INFORMANT: Laura Jackson
Address: 4322 Leland St. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure
4221
DUE TO (b): Arterio sclerotic cardio vascular disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute viral upper respiratory infection
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1955 to Dec. 27, 1967, that (I) (we) last saw the deceased alive on Dec. 26, 1967, and that death occurred at 5:05 AM, from causes and on the date stated above.

22a. SIGNATURE: Alfred S. Norton
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/27/67
22c. PHYSICIAN'S NAME (Type): Dr. Alfred Norton
22d. ADDRESS: 7710 Dwight Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-27-67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City or Town) (County) (State): Suitland Md.

24. FUNERAL DIRECTOR: Robert A. Pumphrey
ADDRESS: 7557 Wisconsin Bethesda Md.
25a. REC'D BY REGISTRAR
DATE: DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

17383

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17384

1. DECEASED-NAME (Type or print) First: Esther Middle: — Last: Sures

2a. DATE OF DEATH Month: Dec. Day: 23 Year: 1967

2b. HOUR: 5:30 PM

3. SEX: Female

4. RACE: WHITE

5. DATE OF BIRTH: APRIL, 1864

6. AGE (In years last birthday): 103 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (State or foreign country): Russia

7b. CITIZEN OF WHAT COUNTRY? U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Bethesda Silver Spring Nursing Home

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): H.W.

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: D.C.

13b. COUNTY:

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 4501 Conn. Ave. N.W.

14. FATHER'S NAME First: A BRAHAM Middle: H. Last: GOLDEN

15. MOTHER'S MAIDEN NAME First: UNKNOWN Middle: Last:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.

17. INFORMANT Address: PHILIP SURES 4740 CONN. AVE. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Broncho-Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hr.

491X

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteria Sclerosis.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this ~~hospital~~) attended the deceased from 12/22, 1967, to 12/23, 1967, that (I) (~~we~~) last saw the deceased alive on 12/23 1967, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Samuel Dessoff DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 12/23/67

22d. PHYSICIAN'S NAME (Type): SAMUEL DESSOFF

22e. ADDRESS: 302-18ST N.W. WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (specify): Burial

23b. DATE: 12/26/67

23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Garden

23d. LOCATION (City or Town) (County) (State): Falls Church, Va.

24. FUNERAL DIRECTOR: B. DANZANSKY & SONS ADDRESS: 3501 14th St. N.W.

25a. REC'D BY REGISTRAR DATE: DEC 28 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17384 — 17385

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa Nursing Home {12325 New Hampshire Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: PG GEO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Forestville
d. STREET ADDRESS: 3418 83rd Ave.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: E. — Last: Tapscott

4. DATE OF DEATH: Month: December — Day: 17 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 7-16-1894
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): D.C. Transit Operator
10b. KIND OF BUSINESS OR INDUSTRY: Bus Driver
11. BIRTHPLACE (County & State, or foreign country): Clark County, Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: James E. Tapscott
14. MOTHER'S MAIDEN NAME: Henrietta Stickles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 578-10-6713
17. INFORMANT: Mary B. Tapscott — Address: 3418 - 83rd Avenue N. Forestville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Chronic bronchitis / Emphysema — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5020

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July, 1965, to 17 Dec, 1967, that (I) (~~we~~) last saw the deceased alive on 12/14/1967, and that death occurred at 6P M, from causes and on the date stated above.

22a. SIGNATURE: William Harvey M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 17 Dec '67
22c. PHYSICIAN'S NAME (Type): William Harvey
22d. ADDRESS: 2121 Penn. Ave NW

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 20 1967
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges Co. Md.

24. FUNERAL DIRECTOR: Clark E. Wisor — Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17385

CERTIFICATE OF DEATH

17386

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 10201 Grosvenor Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-1

3. NAME OF DECEASED (Type or print): First: Mildred; Middle: M.; Last: Taylor
4. DATE OF DEATH: Month: Dec.; Day: 27; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-6-01
9. AGE (In years lost birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife-Organist
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William T. Matthias
14. MOTHER'S MAIDEN NAME: Ethel Copplestone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 578-62-5429
17. INFORMANT: Rev. W. Donald Taylor - Son
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS
194X
DUE TO
(b): CARCINOMA OF THYROID — 3 YEARS
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): No
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MARCH, 1966, to DEC, 1967, that (I) (we) last saw the deceased alive on DEC 26th 1967, and that death occurred at 1:30 AM, from causes and on the date stated above.

22a. SIGNATURE: Madeloff
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/27/67
22c. PHYSICIAN'S NAME (Type): MADELOFF, MICHAELS.
22d. ADDRESS: 504 Elderwood Rd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/29/67
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek
23d. LOCATION (City or Town) (County) (State): Washington D. C.
24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 Rock Pike Rockville, Maryland
25a. REC'D BY REGISTRAR: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

1

17386

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17387

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1 day 1½ hr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. SAN. + HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
d. STREET ADDRESS: 7458 SAN JUAN DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOSEPH Middle: UPTON B Last: THOMPSON
4. DATE OF DEATH: Month: 12 Day: 10 Year: 1967
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-17-37
9. AGE (In years last birthday): 30 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: Philco Ford Corp.
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: UPTON THOMPSON
14. MOTHER'S MAIDEN NAME: MIRIAM DRURY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes. (If yes give war or dates of service): U.S NAVY '64
16. SOCIAL SECURITY NO.: 219-34-9257
17. INFORMANT: Hosp. Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARRHEST
DUE TO (b) LYMPHO SARCOMA
DUE TO (c) pan cytopenia

2001

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on Dec 10 1967, and that death occurred at 10:55 AM, from causes and on the date stated above.

22a. SIGNATURE: Judy Sadeghian M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 11200 LOCKWOOD DR. SILVERSPRING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: DEC. 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: ST. JOHNS CHURCH CEMETERY
23d. LOCATION (City or Town) (County) (State): HOLLYWOOD, ST. MARY'S, MD.

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY ADDRESS: LEONARDTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17387

CERTIFICATE OF DEATH

17388

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WEST HAVEN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5310 WRILEY RD. (D.C. 20016)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WEST HAVEN 15.1
d. STREET ADDRESS: 5310 WRILEY RD. (D.C. 20016)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle LARDNER Last TOBIN
4. DATE OF DEATH: Month DEC. Day 7 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/19/1883
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): NILES, MICHIGAN
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: HENRY LARDNER
14. MOTHER'S MAIDEN NAME: LENA B. PHILLIPS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 081-01-6807
17. INFORMANT: (daughter) ANNE WILLCOX Address: 5310 WRILEY RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH ± 30 min.
331X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ASTHMA – ARTERIOSCLEROTIC HEART DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB, 1967, to DEC, 1967, that (I) (we) last saw the deceased alive on AUG 2 1967, and that death occurred at 6:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Henry D. Ecker — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/7/67
22c. PHYSICIAN'S NAME (Type): HENRY D. ECKER MD
22d. ADDRESS: 916-19th St. N.W. - DC 20006

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE THEREOF: 12/8/1967
23c. NAME OF CEMETERY OR CREMATORY: Zion Episcopal Church Cem. Douglaston, L.I. N.Y.
23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: Joseph Gawler's Sons — ADDRESS: 5130 Wisconsin Ave N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: DEC 15 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Md. Medical Examiner - 12/7/67 MHE

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17388

CERTIFICATE OF DEATH

17389

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park.
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital
d. STREET ADDRESS: 1309 Locust Rd, N.W.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: —
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia 47.3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha Middle: Frances Last: Todd
4. DATE OF DEATH: Month: December Day: 15 Year: 19 67
5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-1-85
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: EDUCATION
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Henry Riggin
14. MOTHER'S MAIDEN NAME: Emily Price
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 579-42-7132 yes
17. INFORMANT: Hollis Todd Chesterfield, Missouri Address: Washington Sanitarium & Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 18 days
332X
DUE TO (b): Cerebro-sclerosis — Undetermined
DUE TO (c): Rheumatoid Arthritis — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arterio-sclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1957 to Dec 15, 1967 that (I) (we) last saw the deceased alive on Dec 14 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: George L Ball
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 15, 1967
22c. PHYSICIAN'S NAME (Type): George L Ball
22d. ADDRESS: 10620 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/18/1967
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville, Maryland
24. FUNERAL DIRECTOR: C. Glen Carter
ADDRESS: Silver Spg. Md.
Warner E. Pumphrey, Inc. 8434 Ga. Avenue
25a. REC'D BY REGISTRAR DATE: DEC 21 1967
25b. REGISTRAR'S SIGNATURE: J Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Generalised Arteriosclerosis

1

17389

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17390

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 5 weeks ~~24 days~~
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 151
d. STREET ADDRESS: 12515 Georgia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jane Middle: Francis Last: Tothill
4. DATE OF DEATH: Month: Dec Day: 12 Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/4/06 ~~[illegible]~~
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): DistrictOfColumbia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Bean
14. MOTHER'S MAIDEN NAME: Catherine Kerr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Lionel A. Tothill, Sr. Address: 12515 Georgia Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PulmonarySaddleEmbolisDueToPeritonitis — INTERVAL BETWEEN ONSET AND DEATH: 1 Week
DUE TO (b): MultiplePeritonealAbscesses
DUE TO (c): PerforatedCarcinomaOfSigmoidColon(1Week)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1533

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/15, 1967, to 12/12, 1967, that (I) (we) last saw the deceased alive on 12/11 1967, and that death occurred at 11:25 A.M., from causes and on the date stated above.

22a. SIGNATURE: Harold S. Tidler M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/12/67
22c. PHYSICIAN'S NAME (Type): Harold S. Tidler
22d. ADDRESS: 8402 Fenton Street, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. John's Forest Glen
23d. LOCATION (City or Town) (County) (State): Forest Glen, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter
ADDRESS: 8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

7

1

17390

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17391

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

25

1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: --Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore — 0-2
d. STREET ADDRESS: 5134 Alberta Avenue 21236
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: Philip — Last: Trumpe

4. DATE OF DEATH: Month: December — Day: 22 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6 March 1924
9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lithographer
10b. KIND OF BUSINESS OR INDUSTRY: Cotton
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond Trumpe
14. MOTHER'S MAIDEN NAME: Cyvilla Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): 1942-1946
16. SOCIAL SECURITY NO.: 217-16-8500
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 Hours
DUE TO
(b) Coronary Atherosclerosis — 5 Years
DUE TO
(c) Endogenous Hyperlipemia — 43 Years

4201

Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from December 5, 19 67, to December 22, 19 67, that (I) (we) last saw the deceased alive on December 22 19 67, and that death occurred at 4:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Ferid Murad — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1967 23 December
22c. PHYSICIAN'S NAME (Type): Ferid Murad, MD.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-27-1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore, Co. Md.

24. FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 740 1/2 Belair Road
25a. REC'D BY REGISTRAR: DATE DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

BB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17391 **CERTIFICATE OF DEATH** 17392

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE 16.2
d. STREET ADDRESS: 8306 14th AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MORTON Middle Last UNTERMAN
4. DATE OF DEATH: Month DECEMBER Day 13 Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-15-1911
9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: AUTOMOBILE
11. BIRTHPLACE (County & State, or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: ISAAC UNTERMAN
14. MOTHER'S MAIDEN NAME: ANNA SICKLICK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 111-09-9888
17. INFORMANT: Diana Bengis Address: 658 W. 188th Street New York, New York

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 5 Min.
433.0
DUE TO
(b) Congestive heart failure, acute — 1 Hr.
DUE TO
(c) Arteriosclerotic cardio vascular disease — 5 Yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): diabetes mellitus.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/15, 1967 to 12/13, 1967, that (I) (we) last saw the deceased alive on 12/13 1967, and that death occurred at 9:10 AM, from causes and on the date stated above.

22a. SIGNATURE: Myron L Lenkin M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-13-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-17-1967
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City or Town) (County) (State): Falls Church Va.
24. FUNERAL DIRECTOR: Goldberg Funeral Home ADDRESS: 4217 9th Street N. W.
25a. REC'D BY REGISTRAR DATE: DEC 20 1967
25b. REGISTRAR'S SIGNATURE: J Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17392

CERTIFICATE OF DEATH

17393

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8704 Irvington Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ethel Middle: Mae Last: Urcado
4. DATE OF DEATH: Month: December Day: 8 Year: 19 67
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/5/1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Washington - DC
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Tippett
14. MOTHER'S MAIDEN NAME: Genvie unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: 213-48-2715
17. INFORMANT: Mrs Welsh — Address: (daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b) Myocardial infarct — 2 weeks
DUE TO (c) Coronary atherosclerosis — YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/22, 19 67, to 12/8, 19 67, that (I) (we) last saw the deceased alive on 12/8 19 67, and that death occurred at 5:55 AM from causes and on the date stated above.

22a. SIGNATURE: Sidney J. Malawer M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/8/67
22c. PHYSICIAN'S NAME (Type): Sidney J. Malawer
22d. ADDRESS: 8218 Wisconsin Ave. Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/11/67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Mausoleum
23d. LOCATION (City or Town) (County) (State): Bladensburg, (P.G.Co) Md.
24. FUNERAL DIRECTOR: Joseph Gawler's Sons
ADDRESS: 5130 Wisconsin Av.N.W. Wash.D.C.
25a. REC'D BY REGISTRAR DATE: DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17393 17394

1. DECEASED-NAME (Type or print): First RINZE Middle VANDER Last VEEN
2a. DATE OF DEATH: Month Dec Day 28 Year 1967
2b. HOUR: 5:35 P.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: May 29-1915
6. AGE (In years lost birthday): 52 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Holland
7b. CITIZEN OF WHAT COUNTRY? US
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Gaithersburg
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 22 No Summit
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY: IBM
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: Gaithersburg
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 22 No. Summit
14. FATHER'S NAME First Middle Last: Rinze A. VanderVeen
15. MOTHER'S MAIDEN NAME First Middle Last: Martha K. Elhome
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes (If yes give war or dates of service): WW2
16b. SOCIAL SECURITY NO.: 113-07-0959
17. INFORMANT: Margaretha W. VanderVeen. Address: Gaithersburg 22N. Summit Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute Myocardial Infarction — 30 min.
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROSIS — YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE
19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Summer, 1967, to Dec 28, 1967, that (I) (we) last saw the deceased alive on Dec 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Steven Conway MD — DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: Dec 28 1967
22d. PHYSICIAN'S NAME (Type): Steven Conway MD
22e. ADDRESS: 570 No Frederick Gaithersburg, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: 12-30-67
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln
23d. LOCATION (City or Town) (County) (State): Bladensburg. Md.
24. FUNERAL DIRECTOR: Ernest C. Gartner — ADDRESS: Ernest C. Gartner. Gaithersburg. Md.
25a. REC'D BY REGISTRAR DATE JAN 3 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5 41
30M REV. 1/68

1

17394

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film G396 1/2/68 kk

CERTIFICATE OF DEATH

17395

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Dist/ of Col.
b. COUNTY: - - -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4000 Massachusetts Ave. N.W.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

47.3

90

3. NAME OF DECEASED (Type or print): First: MARY; Middle: E.; Last: VENCILL

4. DATE OF DEATH: Month: December; Day: 21; Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 1-6-1878
9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Cass Morris
14. MOTHER'S MAIDEN NAME: Mary Ellen Devlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): - -
(If yes give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: - -
17. INFORMANT: Genevieve Vencill- See Item No. 2 — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Thrombosis
DUE TO
(c): Generalized Cardiovascular renal Disease

442x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: None 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

3

21. I certify that (I) (this hospital) attended the deceased from 12/13, 1967, to present 19__, that (I) (we) last saw the deceased alive on 12/20 1967, and that death occurred at 11:10 AM from causes and on the date stated above.

22a. SIGNATURE: John B. Umhau
M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12/22/67
22c. PHYSICIAN'S NAME (Type): JOHN B. UMHAU MD
22d. ADDRESS: 8805 Conn. Ave. Chevy Chase Md

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 12-22-1967
23c. NAME OF CEMETERY OR CREMATORY: Masonis Cemetery
23d. LOCATION (City or Town) (County) (State): Silver City, N.M.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. %130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE DEC 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17395 **CERTIFICATE OF DEATH** 17396

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 1 da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt
d. STREET ADDRESS: 5910 Cherrywood Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16,2

3. NAME OF DECEASED (Type or print): First ENRIQUE Middle MIRALLES Last VERA
4. DATE OF DEATH: Month 12 Day 18 Year 1967
5. SEX: M
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 17, 1967
9. AGE (In years last birthday): ~~1 day~~ — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 23 Min. 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): —
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ENRIQUE MARTINEZ VERA
14. MOTHER'S MAIDEN NAME: LILIAN MIRALLES SILVA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: ENRIQUE VERA — Address: GREENBELT, MD., 5910 CHERRYWOOD TR.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
776 X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6 12/15, 1967 to 6 12/18, 1967, that (I) (we) last saw the deceased alive on 12/18 1967, and that death occurred at 6 P.M. from causes and on the date stated above.

22a. SIGNATURE: M. Moores — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-18-67
22c. PHYSICIAN'S NAME (Type): MARVIN MOORES
22d. ADDRESS: 1003 Spring St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/23/67
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem
23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.
24. FUNERAL DIRECTOR: Tyson Wheeler — ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR: DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

7-263805

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17396

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17397

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 3606 Dundee Dr ~~10003 Mayfield Drive~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: Virginia; Last: Wagner
4. DATE OF DEATH: Month: Dec.; Day: 15; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 1, 1902
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Mineral, Virginia
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Henry Johnson
14. MOTHER'S MAIDEN NAME: ~~Johnson~~ Angelina Paterson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lewis H. Croce — Address: 3608 Dundee Dr. Chevy Chase Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary insufficiency, acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden.
DUE TO
(b) Coronary arteriosclerosis, severe — Years.
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PEREORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OE DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John H. Bell M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 12/15/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/18/67
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln
23d. LOCATION (City or Town) (County) (State): Bladensburg, P.G. Md.
24. EUNERAL DIRECTOR: Joseph Gawler's Sons — ADDRESS: Wash, D.C. 5130 Wisconsin Ave
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

x

4 1

FOR STATE HEALTH DEPT.

17397

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17398

1. PLACE OF DEATH
a. COUNTY Montgomery. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda.
c. LENGTH OF STAY IN 1b 6 Mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Topaz House 4400 East West Hgwy.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda.
d. STREET ADDRESS 4400 East West Hgwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Walter Middle: (NMI) Last: Wallace.
4. DATE OF DEATH Month: Dec. Day: 10 Year: 1967
5. SEX M.
6. COLOR OR RACE W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 3, 1905
9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronics Engr
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Philipines.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Walczykowski
14. MOTHER'S MAIDEN NAME Manuela Martinis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II
16. SOCIAL SECURITY NO. 579-40-2905
17. INFORMANT Wife Address Same as Item 2. Metta R. Wallace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficency Acute — INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
DUE TO
(b) Cardiovascular Disease — years.
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John G. Ball M.D.
EXAMINER'S NAME (Type) JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED 12/10/67
Address (Street, city, town, or county) Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 12-13-67
23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.
23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, ADDRESS Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE DEC 15 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VR-M3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

12

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17398

CERTIFICATE OF DEATH

17399

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10401 GROSVENOR PLACE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE 15.1
d. STREET ADDRESS: 10401 GROSVENOR PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle Lost WEINBERG
4. DATE OF DEATH: Month 12 Day 18 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-7-1907
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF EMPLOYED
10b. KIND OF BUSINESS OR INDUSTRY: ART DEALER
11. BIRTHPLACE (County & State, or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ISIDORE WEINBERG
14. MOTHER'S MAIDEN NAME: ANNA REINANEC
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: MRS BENA WEINBERG — Address: SAME AS 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4201
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 4-26, 1948, to Dec 18, 1967, that (I) (we) last saw the deceased alive on 12-7-1967, and that death occurred at 9:50 AM, from causes and on the date stated above.

22a. SIGNATURE: Herbert Abramson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-18-67
22c. PHYSICIAN'S NAME (Type): HERBERT ABRAMSON, M.D.
22d. ADDRESS: 1250 - Conn Ave NW · Wash DC

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-20-1967
23c. NAME OF CEMETERY OR CREMATORY: New Montefiore Cem.
23d. LOCATION (City or Town) (County) (State): Pinelawn, L.I. N.Y.
24. FUNERAL DIRECTOR: GOLDBERG FUNERAL HOME — ADDRESS: 4217 9th St. N.W.
25a. REC'D BY REGISTRAR — DATE: DEC 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Jung

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

D.M.E. Dr. John Ball Notified 1400

VR A15 (4)
20 M 1/66

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17399

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b: 10-28-67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: ARLINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARLINGTON, VIRGINIA 83.3
d. STREET ADDRESS: 231 N George Mason Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle T. Last Whaley
4. DATE OF DEATH: Month DEC. Day 14 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-25-1909
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON DC
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: CHARLES KAISER
14. MOTHER'S MAIDEN NAME: CLARA ANN DEITRICH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 557-03-7747
17. INFORMANT: MARGARET M FELTON — Address: Kensington Md. 10225 Kens. Pkway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cachexia
199.2
DUE TO (b) Carcinomatosis
DUE TO (c) Primary Pelvic

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 7, 1967 to 12/14, 1967, that (I) (we) last saw the deceased alive on Dec 14 1967, and that death occurred at 3 50 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/14/67
22c. PHYSICIAN'S NAME (Type): ROBERT T. THIBADEAU
22d. ADDRESS: ROCKVILLE, MD. 20852

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-16-67
23c. NAME OF CEMETERY OR CREMATORY: NATIONAL MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): FALLS CHURCH, VA.
24. FUNERAL DIRECTOR: F.J. COLLINS — ADDRESS: 3821-14th ST. N.W. WASH. D.C.
25a. REC'D BY REGISTRAR — DATE DEC 18 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17400 17401

1. DECEASED-NAME (Type or print) First: FLORENCE Middle: HENDERSON Last: WHEELER
2a. DATE OF DEATH Month Day Year: Dec. 24 67
2b. HOUR: 10:15 P M
3. SEX: Female
4. RACE: CAUC.
5. DATE OF BIRTH: 4-31-1878
6. AGE (In years last birthday): 89 YRS. IF UNDER 1 YEAR: MONTHS 6 DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): INDIANA
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: MONTGOMERY Md.
10. CITY OR TOWN OF DEATH: WHEATEN
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): UNIVERSITY NURSING Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOME MAKER
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: BETHESDA
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET AND NUMBER: 7521 SPRING LAKE DR.
14. FATHER'S NAME First Middle Last: Unknown
15. MOTHER'S MAIDEN NAME First Middle Last: Unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service):
16b. SOCIAL SECURITY NO.: 309-09-0305
17. INFORMANT Address: NURSING RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Insufficiency

4211

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from 1965, 19____, to 12-24, 1967, that (I) (~~we~~) last saw the deceased alive on Dec 24, 1967, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert Kramer M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 12/24/67
22d. PHYSICIAN'S NAME (Type): ROBERT KRAMER
22e. ADDRESS: 8484 16th ST. SS. Md.

23a. ~~BURIAL~~ CREMATION, REMOVAL (Specify)
23b. DATE: 12/28/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory.
23d. LOCATION (City or Town) (County) (State): Pr Geo Co Md.

24. FUNERAL DIRECTOR: W.K. Huntemann & Son Funeral Home ADDRESS: 5732 Georgia Ave N.W.
25a. REC'D BY REGISTRAR DATE: DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

3 1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17401 17402

M

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 17 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Oak Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chillum
d. STREET ADDRESS: 625 Sheridan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16.2

90

3. NAME OF DECEASED (Type or print): First: GERTRUDE Middle: Cora Last: WHELAN
4. DATE OF DEATH: Month: DEC. Day: 29 Year: 1967
5. SEX: F
6. COLOR OR RACE: wh.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 26, 1883
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired House Cleaner
10b. KIND OF BUSINESS OR INDUSTRY: District Govt.
11. BIRTHPLACE (County & State, or foreign country): Georgetown, DC
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-52-8293
17. INFORMANT: Wallace F. Whelan Address: 12717-Rigdale Ter. S. S. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: One week
DUE TO (b) Cerebral Arteriosclerotic Syndrome
DUE TO (c) Generalized Arteriosclerosis

334X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pt. showed progressive deterioration and died of Terminal Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. **I certify** that (I) (this hospital) attended the deceased from July 9, 1966 to 12/29, 1967, that (I) (we) last saw the deceased alive on 12/27 1967, and that death occured at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R S Williams M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): R. S. WILLIAMS
22d. ADDRESS: 35 NEW YORK AVE. NW.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan 3, 1968
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City, town or county) (State): Washington, DC

24. FUNERAL DIRECTOR'S SIGNATURE: C. Glen Carter ADDRESS: 8434- Ga. Ave
Warner E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE JAN 9 1968
25b. REGISTRAR'S SIGNATURE: Charles Gray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17402

CERTIFICATE OF DEATH

17403

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 1 yr.5 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4977 Battery Lane, Apt. ~~XXXX~~ 305
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: H. — Last: White
4. DATE OF DEATH: Month: Dec. — Day: 16, — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-27-1895
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Hanson
14. MOTHER'S MAIDEN NAME: Lizzie Swenson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-12-5580A
17. INFORMANT: Husband Lincoln White — Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): TERMINAL BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS
DUE TO (b): CEREBRAL ATROPHY — 1 1/2 YRS
DUE TO (c): MASSIVE C.V.A.'s — 1 1/2 YRS.
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from NOV. 20, 1949, to DEC 16, 1967, that (I) (~~we~~) last saw the deceased alive on DEC. 11 1967, and that death occurred at 7:23 AM, from causes and on the date stated above.

22a. SIGNATURE: Robert G. Angle — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: DEC. 16, 1967
22c. PHYSICIAN'S NAME (Type): ROBERT G. ANGLE
22d. ADDRESS: 5009 Del Ray Ave. Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-18-67
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland
24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

~~13~~ 1

17403

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17404

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annandale 83-3
d. STREET ADDRESS: 4509 Old Columbia Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

26

3. NAME OF DECEASED (Type or print): First: Lloyd — Middle: Franklin — Last: WHITE

4. DATE OF DEATH: Month: December — Day: 31 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Aug. 2, 1906

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Johnson County, N.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas L. White

14. MOTHER'S MAIDEN NAME: Bessie Guthridge

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): 1927 to 1957

16. SOCIAL SECURITY NO.: 224-52-3231

17. INFORMANT: Mrs. Eleanor White — Address: Annandale, Va. 4509 Old Columbia Pike

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Supurative Peritonitis
576 X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 2, 19 67, to Dec. 31, 19 67, that ~~I~~ (we) last saw the deceased alive on Dec. 31, 19 67, and that death occurred at 1155A M, from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 31 DEC 67

22c. PHYSICIAN'S NAME (Type): W.R. Hix, M.D.

22d. ADDRESS: Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park

23d. LOCATION (City or Town) (County) (State): Arlington, Va.

24. FUNERAL DIRECTOR: Everly-Wheatley — ADDRESS: 1500 West Braddock Road, Alexandria, Virginia

25a. REC'D BY REGISTRAR — DATE: JAN 8 1968

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
25M 1/67

1

17404

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17405

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington MARYLAND
b. COUNTY: D. C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 4301 Warren St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Agnes Middle Virgina Last Williams
4. DATE OF DEATH: Month Dec. Day 30 Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 18 1886
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): Fredericksburg Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Sanford Allen
14. MOTHER'S MAIDEN NAME: Sarah Henderson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 223 66 8344
17. INFORMANT: Mrs Bertha Henderson Address: 4301 Warren ST Washington, DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2+ days
DUE TO
(b): CONGESTIVE HEART FAILURE — WEEKS
DUE TO
(c): ARTERIO SCLEROTIC HEART FAILURE — YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4500
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): GEN'L ARTERIO SCLEROSIS UREMIA
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/9, 1967, to PRESENT 19__, that (I) (we) last saw the deceased alive on 12/29 1967, and that death occurred at 3 A M, from causes and on the date stated above.

22a. SIGNATURE: Charles Savarese, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/30/67
22c. PHYSICIAN'S NAME (Type): CHARLES SAVARESE, M.D.
22d. ADDRESS: 11125 ROCKVILLE PK, ROCKVILLE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF:
23c. NAME OF CEMETERY OR CREMATORY: Mt View Baptist
23d. LOCATION (City or Town) (County) (State): King George Cty Md
24. FUNERAL DIRECTOR: Robert A Pumphrey ADDRESS: 7557 Wisconsin Ave Bethesda, Md
25a. REC'D BY REGISTRAR DATE: JAN 5 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

A34
4/18/68

VR A15 (4)
25M 1/67

6

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17405

CERTIFICATE OF DEATH

17406

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington, D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, DC
d. STREET ADDRESS: 5922 13th St., NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Leslie Middle Franklin Lost Williams

4. DATE OF DEATH: Month 12 Day 9 Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/26/1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warehouseman
10b. KIND OF BUSINESS OR INDUSTRY: D.C. School Dist.
11. BIRTHPLACE (County & State, or foreign country): Phila., Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Williams
14. MOTHER'S MAIDEN NAME: Ida ~~Eliza~~ Liza Lecture

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 197-09-4332
17. INFORMANT: Gertrude Williams — Address: 5922 - 13th Street, N.W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) onset two years - — 2 years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-7, 19 67, to 12-9, 19 67, that (I) (we) last saw the deceased alive on 12-9, 19 67, and that death occurred at 2:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Myron L Lenkin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-9-67
22c. PHYSICIAN'S NAME (Type): Myron L. Lenkin
22d. ADDRESS: 2309 Shorefield Rd, Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: C. Glen Carter — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR DATE DEC 13 1967
25b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

17406

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17407

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cabin John.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 25 Carver Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cabin John.
d. STREET ADDRESS: 25 Carver
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia Middle: E. Last: Williams.
4. DATE OF DEATH: Month: Dec. Day: 19 Year: 1967
5. SEX: Fe.
6. COLOR OR RACE: Colored.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 16, 1916
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Charwoman
10b. KIND OF BUSINESS OR INDUSTRY: G.S.A.
11. BIRTHPLACE (State or foreign country): Montvale, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Allen Curtis
14. MOTHER'S MAIDEN NAME: Mary A. Carter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Charles E. Williams Address: 25 Carver Rd., Cabin John, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
465X IMMEDIATE CAUSE (a) Pulmonary infarction, bilateral — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Bull M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 12/20/67.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/23/67
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): Montvale, Va.
24. FUNERAL DIRECTOR: McGuire Fun. Serv. Inc. ADDRESS: 1820 Ninth St. N.W. Wash., D.C.
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17407 17408

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 575 Thayer Avenue

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 575 Thayer Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle KATE — Last WILT
4. DATE OF DEATH: Month 12 — Day 27 — Year 1967
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/25/1883
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: E. M. Abraham
14. MOTHER'S MAIDEN NAME: Katherine Yauger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 220-54-0177
17. INFORMANT: Mrs. Ruth Holland — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

INTERVAL BETWEEN ONSET AND DEATH: unknown.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April, 1967 to Dec, 1967 that (I) (we) last saw the deceased alive on Dec 26 1967 and that death occured at 7:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Bernard A. Fitzgerald M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-27-67
22c. PHYSICIAN'S NAME (Type): BERNARD A. FITZGERALD
22d. ADDRESS: 217 UNIV. BLVD E, SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/30/67
23c. NAME OF CEMETERY OR CREMATORY: Sylvan Heights Cemetery
23d. LOCATION (City, town or county) (State): Uniontown, Pennsylvania
24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons, Inc. — ADDRESS: Washington, D. C.
25a. REC'D BY REGISTRAR — DATE: JAN 3 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

CLEARED WITH MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17408

CERTIFICATE OF DEATH

17409

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 7904-16th. St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Merle Middle: K. Last: Wood
4. DATE OF DEATH: Month: December Day: 25 Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 30, 1898
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Federal employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Horace H. Wood
14. MOTHER'S MAIDEN NAME: Nellie Kuhn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-60-1466
17. INFORMANT: Ruth R. Wood Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH: 10 mos
157X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/23, 1967, to 12/25, 1967 that (I) (we) last saw the deceased alive on 12/24 1967 and that death occurred at 6 A M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/25/67
22c. PHYSICIAN'S NAME (Type): G H Kreuzburg
22d. ADDRESS: 7852 16th St NW Wash DC

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE THEREOF: 12/28/67
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): Toledo, Ohio

24. FUNERAL DIRECTOR: The S.H. Hines Company ADDRESS: 2901 14th St. N.W. Washington, D.C.
25a. REC'D BY REGISTRAR DATE DEC 27 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17409

CERTIFICATE OF DEATH

17410

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Kensington~~ Silver Spring
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Silver Spring Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
Mary Kensington b. COUNTY Montgomery
Maryland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 15-1
d. STREET ADDRESS 3912 Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Martin Middle Herbert Last Wright
4. DATE OF DEATH Month 12 Day 24 Year 67 19

5. SEX m
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3 31 00
9. AGE (In years last birthday) 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Washington, DC
12. CITIZEN OF WHAT COUNTRY US

13. FATHER'S NAME Herbert Wright
14. MOTHER'S MAIDEN NAME Elva Manning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW1
16. SOCIAL SECURITY NO. 218 05 6066
17. INFORMANT Address Ethel W. Wright same item # 2-wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH 3 hrs
DUE TO
(b) Chronic Myocardial Disease — 8 years
DUE TO
(c) Chronic Arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 19 ~~66~~, to 12-24, 19 ~~67~~, that (I) (we) last saw the deceased alive on Nov. 19 ~~67~~ 2, and that death occurred at 12:24 P.M., from causes and on the date stated above.

22a. SIGNATURE J. S. Rogers M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 12-24-67
22c. PHYSICIAN'S NAME (Type) J.S. Rogers
22d. ADDRESS 1919 Seminary Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 12/28/67
23c. NAME OF CEMETERY OR CREMATORY Parklawn
23d. LOCATION (City or Town) (County) (State) Rockville, Md.

24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home — 1331 Rockville Pike ADDRESS Tyson Wheeler Rockville Md
25a. REC'D BY REGISTRAR DATE DEC 29 1967
25b. REGISTRAR'S SIGNATURE for Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Mailed by Dr. Rog. 12.24.67 (Sat) 99

VR A15 (4)
25M 1/67

1

17410

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17411

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton Silver Spring
c. LENGTH OF STAY IN 1b: 4 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11931 Viers Mill Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton 15-1
d. STREET ADDRESS: 11931 Viers Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Robert Last Zehner
4. DATE OF DEATH: Month Dec. Day 18 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/27/19
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Manager
10b. KIND OF BUSINESS OR INDUSTRY: Hi-Fi Equipment
11. BIRTHPLACE (County & State, or foreign country): Anderson, Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Floyd Zehner
14. MOTHER'S MAIDEN NAME: Irene Sandifer Shaffer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes WW II - Korea
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT: Margaret Zehner
Address: 11931 Viers Mill Road Wheaton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
(b) Arteriosclerotic Heart Disease — 2 years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June, 1966 to Dec 18, 1967, that (I) (~~we~~) last saw the deceased alive on Dec 17 1967, and that death occurred at 3 ~~PM~~ AM, from causes and on the date stated above.

22a. SIGNATURE: Raymond T. Benack MD M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/18/67
22c. PHYSICIAN'S NAME (Type): RAYMOND T. BENACK MD
22d. ADDRESS: 4115 Colie Dr. Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: Warner Clark Humphrey Inc. Clark & Wisor
ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66